

MARYLAND ROOM

HEALTH SCIENCES LIBRARY  
UNIVERSITY OF MARYLAND  
BALTIMORE



Digitized by the Internet Archive  
in 2011 with funding from  
LYRASIS Members and Sloan Foundation

<http://www.archive.org/details/bulletinofuniver5959>





of media



editorial board  
George H. Yeager, M.D.,  
(*editor*)  
Mary A. Lantz,  
(*editorial assistant*)  
George Entwistle, M.D.  
Robert B. Goldstein, M.D.  
Donald T. Lewers, M.D.  
Frederick J. Ramsay, Ph.D.  
Edwin H. Stewart Jr., M.D.  
Wilfred H. Townsend, M.D.  
W. Douglas Weir, M.D.  
William J. R. Dunseath, M.D.  
John M. Dennis, M.D.  
Francis W. O'Brien  
(*ex-officio*)

# BULLETIN

**university of maryland school of medicine**

February, 1974

Vol. 59

No. 1

Erratum—

Previous issue dated Winter, 1973 Volume 57 No. 4 should  
read Fall, 1973 Volume 58 No. 4

<b>comments by the chancellor</b>	2
<b>introducing students to a medical career</b>	3
<b>university of maryland hospital budget history—1924</b>	6
<b>experiment in chile</b>	9
<b>the admissions process</b>	11
<b>the visiting traineeship in-service program</b>	14
<b>4th annual maryland day medical alumni conference, amityville, n.y.</b>	16
<b>continuing education offerings</b>	17
<b>the university of maryland hospital medical board—a profile</b>	18
<b>house staff message</b>	19
<b>a word from the president</b>	20
<b>new hospital cafeteria</b>	X 77-1569 23
<b>faculty news—new appointments, promotions and resignations</b>	25
<b>alumni chatter</b>	26
<b>alumni news report</b>	28

# Officers and board of Directors of the Medical Alumni Association 1973-74

PRESIDENT:  
William J. R. Dunseath, M.D. '59

PRESIDENT-ELECT:  
Robert B. Goldstein, M.D. '54

SECRETARY:  
Joan Raskin, M.D. '55

TREASURER:  
John F. Strahan, M.D. '49

VICE-PRESIDENT:  
Herbert Berger, M.D. '32

VICE-PRESIDENT:  
Benjamin M. Stein, M.D. '35

MEMBER EX-OFFICIO:  
John M. Dennis, M.D. '45

MEMBER EX-OFFICIO:  
Edward F. Cotter, M.D. '35

MEMBER EX-OFFICIO:  
Henry H. Startzman, Jr., M.D. '50

MEMBERS OF THE BOARD:  
Joseph S. McLaughlin, M.D. '56  
Salvatore R. Donohue, M.D. '64  
Aristides Alevizatos, M.D. '60  
Eugene J. Riley, M.D. '44  
Joseph D'Antonio, M.D. '46  
James A. Roberts, M.D. '46  
Herbert J. Levickas, M.D. '46  
David R. Will, M.D. '43  
Elijah Saunders, M.D. '60

EXECUTIVE DIRECTOR:  
Francis W. O'Brien

## Information for Contributors

CONTRIBUTIONS: Original typed copy, not carbon copies, and illustrations, requests for exchanges and book reviews, should be forwarded prepaid at the author's risk to the Editor of the University of Maryland School of Medicine Bulletin:

George H. Yeager, M.D., Editor  
Alumni Bulletin  
University of Maryland School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Md. 21201

PREPARATION OF MANUSCRIPTS: Manuscripts, including references, should be typed double spaced on one side of the paper, leaving wide margins. While every effort will be made to guard against loss, it is advised that authors retain copies of manuscripts submitted. All pages should be numbered. Numbers one to ten should be spelled out, except when used for all units of measurement (time, dimension, degrees, weight, volume, dosage, etc.), percentage, and decimals; for numbers above ten, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized. Units of measurement, e.g., dosage, should be expressed in the metric system. Temperature should be expressed in degrees centigrade. Contribution in a foreign language, when accepted, will be translated and published in English.

PREPARATION OF ILLUSTRATIONS: Black and white illustrations will be reproduced free of charge, but the publisher reserves the right to establish a reasonable limit upon the number supplied. Colored illustrations will be published at the author's expense. Black and white photographs should be presented as glossy prints. Line and wash drawings should be black, on white paper, with lettering in black India ink, large enough to be readable after necessary reduction. Large or bulky illustrations should be accompanied by smaller glossy reproductions of the same, to facilitate their circulation among the judging members of the editorial board. Illustrations should be numbered, the tops indicated, and the author's name and the title of the article in brief should appear on the back. A separate typewritten sheet of legends for the illustrations should be supplied.

REFERENCES: A bibliography of numbered references in alphabetical order should appear at the end of the manuscript with corresponding numbering in the text. Bibliographies should conform to the style of the Index Medicus with the exception that the last page number should be omitted, viz: author's name, title of article, name of journal, volume number, first page number, and year of publication in the order named.

### INFORMATION FOR SUBSCRIBERS

The University of Maryland Medical Alumni Association Bulletin is the official publication of the University of Maryland Medical Alumni Association and is published jointly four times annually by the University of Maryland Medical Alumni Association and the Faculty of the University of Maryland School of Medicine. Subscription price is \$5.00 per year in the United States, Canada and Mexico; and other countries \$6.00. Single copies, current and back copies, if available, are priced at \$2.00.

CHANGE OF ADDRESS: Please allow 60 days before date of issue for change of address. Notification should include the old as well as the new address (include Zip Code) with indications of whether the change is temporary or permanent. Please give the name of the journal. Copies will not be replaced without charge unless we receive a request within 60 days of the mailing in the U.S. or within 90 days in all other countries.

Membership subscriptions (University of Maryland Medical Alumni Association) and business relating to membership should be sent to: University of Maryland Medical Alumni Association, University of Maryland School of Medicine, Room 201 Davidge Hall, 522 W. Lombard Street, Baltimore, Maryland 21201.

The Publishers accept no responsibility for opinions expressed by Contributors.

# COMMENTS BY THE CHANCELLOR

Albin O. Kuhn, Ph.D.

As we move toward 170 years of existence of the University of Maryland on this campus, there are many signs that the individual schools, the hospital and the campus as a whole are approaching the years ahead with youthful vigor.

We have been engaged during the past two years in the difficult task of projecting the many activities of the campus into a planning period that extends to 1980. This is essential in order to have an orderly procedure for continuing our present activities and for undertaking the programs that respond to the needs of Maryland citizens. This planning activity leads to the development of a Master Plan for the campus. We now project that the student enrollment will increase by approximately 50% by 1980. This enrollment growth will not be uniform for the various schools but each school is expected to experience an increase in students. In addition, we anticipate extensive growth in continuing education in all of the professions, the development of additional out reach activities and demonstrations and the possible development of additional forms of extension education.

The University of Maryland at Baltimore has been fortunate in the past decade in increasing its land area from less than ten acres to slightly more than twenty-five acres. Notable among the buildings that have been added to the campus in that decade are the Dental School building, the Law School building, the Nursing School building, the North Hospital, major multi-level parking facilities and the acquisition and conversion of Howard Hall for use of the Medical School.

Major construction is underway today on the campus. The addition to Howard Hall that is under construction to add resources for the teaching program of the Medical School is not adequately described by the word addition. It is comparable in size to the Dental building. On the north side of Pratt Street, a new multi-level parking facility for 1,000 cars is underway. This building will have a unique feature in that the entire top floor will be utilized as an in-door physical exercise area accommodating tennis as well as other activities.

On the drawing boards is an additional Medical School Teaching Facility and School of Pharmacy building. In preliminary planning is a new building for the School of Social Work and Community Planning.

In the Master Plan we envision for the years immediately ahead additions to the School of Law and the School of Nursing, an additional facility



*Photograph by Fabian Bachrach*

for Allied Health Programs and a continuing thrust to add to parking space on the campus.

An important continuing objective of each of the schools is the attraction, enrollment and graduation of more blacks. Contrary to the misconceptions of some, quotas are not involved. We have the continuing goal of attracting qualified students in numbers not less than their representation in the population of the State.

Through direct committee work by representatives of the city and representatives of the University, we are finding ways for both the city of Baltimore and the University of Maryland at Baltimore to work together as cooperative participants in the exciting further development of this major metropolitan center of Maryland.

Facilities are important but what happens in the teaching, research and clinical programs is far more important. The Deans of the various schools have been meeting regularly with the Chancellor and have been mapping ways in which important academic strengths in each of the schools can be united to evolve intra professional studies that will improve the opportunities for all students. There appears to be much promise in this approach.

We are attempting to find an additional effective way for the schools to work together. A campus senate has been developed with elected faculty and student representatives and with administrative representatives. In the past, coordination among the schools has been achieved primarily by informal means and by the Deans working with the Chancellor. An effective campus senate will broaden the base of those directly participating in this endeavor.

A sign of the growing awareness of the importance of the campus as an academic center is the sensitivity we now exhibit if someone fails to clearly identify this campus as UMAB—The University of Maryland at Baltimore.

# Introducing Students to A Medical Career Before They Enter Medical School

Keith L. Smith

How do students experience medical school today? Are we able to find a pattern or patterns in the kinds of problems medical students and young practicing physicians face? Are there ways more efficacious than others for coping with these problems? Can these coping methods be effectively taught, to the end that medical students and practitioners can function a little more efficiently, and with less psychological wear and tear to themselves?

On a very modest scale, we have set out to make contribution toward finding answers to the last of these questions.

An impressive number of studies on the basic subject matter have been collected in the medical education and sociological literature. In addition, the medical school and the contacts available through it represent a rich source of first-hand information concerning such questions. Using these information sources, we have organized an elective short-course for students who have been elected to enter the University of Maryland School of Medicine. Called "The Medical Profession: An Introduction for Prospective Practitioners", the course was given for the first time last Spring and Summer to those who are now in the freshman Medical School class. We report here our preliminary evaluations of this initial trial.

## What We Set Out to Accomplish

It would be quite unrealistic, of course, to expect a few hours of course work to produce substantial effects upon a career in which students have already spent many years preparing to enter, and in which they will spend more years in order to reach the stage of independent practice. Further, many of the critical points in this process of becoming a physician have not yet been successfully researched. Perhaps it would be realistic, however, to undertake to provide entering students with an explanatory framework which would make the training process and the early practice years somewhat more understandable, less threatening, and thereby a little more productive.

It could prove useful, for example, to develop some insight into the essential nature of a professional calling, particularly as it applies to medicine, the premier example of a profession in the American occupational structure. The processes by which medical schools produce medical professionals would be useful to understand. The kinds of challenges and problem situations students typically encounter would be worthwhile discussing, together with the most effective ways for dealing with them.

Enrollment in freshman medical classes in this country has increased by about one-third in the past five years; the proportion of minority and women students has also increased. It would be important to further develop understanding, on the part of both majority and minority, of the situations which women and ethnic minorities encounter in medical school and in medical practice.

Medical students are not immune to certain of the risks to which practicing physicians are exposed—drug addiction, suicide and alcoholism, for example. It would be useful to discuss these, too.

## How the Course was Organized

Almost all the incoming students to the medical school resided somewhere in Maryland at the time they applied to enter; this is typical of state supported medical schools everywhere in the country. About nine-tenths of this year's entering class list their residence somewhere in the Baltimore Metropolitan area, the Washington suburbs, or the corridor in between. The reason for this is simple: This is where by far most of the state's population lives. Freshman students came to some extent from all parts of the state, however. An effort was made to bring the course to all major sections of the state, including Western Maryland and the Eastern Shore.

At the time they were accepted into medical school, about one-fourth of this year's freshman class were attending undergraduate colleges outside the state. Sections of the course were organized during spring vacation and during the summer to provide an opportunity for these students to participate.

We wanted to do our best to schedule the course at times which would prove to be most available and convenient for the students involved. Obviously, we had not the slightest idea what the optimal times would be, so we experimented. Four 1½-hour sessions were usually scheduled. The course was offered eleven different times between the first of April and the last of August, sometimes in the afternoons, sometimes

at night, and once on successive Saturdays. Even with this schedule, several students who wanted to take the course could not be fitted in. We think we know how to solve this problem the next time around, however.

In a few of the locations where the course was offered, only one or two incoming medical students resided. In these situations, other undergraduates at the local college in that area, who were interested in entering the medical field, were invited to attend. In the section of the course conducted at the University of Maryland—Eastern Shore, at Princess Anne, all participants fell into this category.

Subject materials for the course were drawn from standard sociological, anthropological and medical education literature, and from extensive discussions with faculty and students at the medical school. Dr. Fred Ramsey, Assistant Dean for Student Affairs, Dr. Robert Harrell, Assistant Dean for Student Affairs, Dr. Robert Derbyshire, until recently Counselor for Married Students, Dr. Maureen Henderson, Chairman of the Department of Social and Preventive Medicine, Dr. Gerard Hunt, Associate Professor of Sociology, and especially Dr. Karl Weaver, Associate Dean of Admissions, were all very helpful in providing needed information. Ms. Pat Falcao, Student Ombudsman, provided continuing information input and evaluation of the course, as well as participating in class discussions. Richard Bittrick, President of the Senior Class, likewise provided valuable input into class discussions.

### **What was Discussed**

Our initial discussions centered around the characteristics which distinguish a profession from all other occupations—concern with a very large and complex body of knowledge, the goal of service rather than maximal economic return, and colleague rather than bureaucratic relations within the profession. This was illustrated by comparisons between physician and chiropractor, business executive and insurance agent.

Next, we discussed briefly the historical development of the medical profession in the United States, followed by a description of the current occupational and income structure of the medical profession. Information was presented on social, demographic and psychological characteristics of students currently entering medical school in this country, followed by a discussion of those circumstances which lead physicians to specialize.

The second session in the course dealt entirely with the medical school experience. We talked about the typical sequence of student attitudes toward the vast amount of knowledge to be in-

gested, the need to develop empathetic rather than sympathetic or indifferent attitudes toward patients, and the ups and downs of student cynicism in different stages of medical training. Some specific problem areas discussed included financial problems, expectations in scholastic performance, combating isolation, the introduction to the cadaver, and the possibility of psychiatric problems. Finally, we talked quite frankly about the current high breakup rate of student marriages (thought to be of the order of 50%). In each case, where a potential problem was brought up and discussed, specific suggestions for successfully coping with the problem were put forward.

The third session dealt with women and ethnic minorities in medicine. Information on recent national trends in medical school enrollments was presented, and comparisons made with the University of Maryland School of Medicine. Data on the relative performance of women in medical school and in practice were summarized. Some of the special problems of women and minority students were discussed.

In the fourth session, we discussed the nature of some of the allied occupations/professions in the health care community: pharmacists, dentists, and nurses. Particular emphasis was placed upon changes which are taking place among these practitioners, which in turn result in changing relationships with physicians.

The course closed with a discussion of some of the special occupational hazards to which practicing physicians are unusually at risk. The relatively high suicide rates among younger physicians was documented, and possible causes discussed. Similarly, meperidine addiction, alcoholism and other mental health problems were discussed. On the other side of the picture, it was pointed out that divorce rates among physicians appear to be relatively low. In a somewhat different area, problems arising from external pressures toward the bureaucratization of medicine were discussed, and some remedies suggested.

### **What Was the Student Response?**

The course was designed as completely voluntary, and without academic credit of any sort. It was made quite clear in the course announcement that students would not earn any Brownie Points from the medical school by participating. Nonetheless, about two-thirds of the incoming class signed up for the course (101 out of 155 entering students). A few students who had been accepted at other medical schools appeared spontaneously. Several spouses of incoming students attended. Finally, 24 students who had not yet

plied to any medical school but were interested in doing so, participated in the Frostburg, Princess Anne, and College Park sections.

Among those who formally signed up for the course, attendance was approximately 85%-90% for the four sessions.

At the end of the four sessions, a few minutes were set aside to discuss the course with the students. Three questions were discussed. 1) the appropriateness of the different subjects covered; 2) whether the course presentation induced feelings of reassurance or of insecurity; 3) what factors might have induced greater participation in the discussions.

Generally speaking, most groups felt the subject matter presented was appropriate and useful. The material having to do with the nature of professions received some mixed views; some thought it could have been omitted, others stated that though they thought it irrelevant at the time, its usefulness became apparent in the later sessions. Some additional subjects were suggested: social, recreational, and professional organization activity on and off campus; living accommodations, parking, and other "housekeeping" information; description of medical specialties and characteristics of those entering them; personal safety on campus.

Students uniformly felt the course material was reassuring and not threatening. One student compared the complete lack of such information in another kind of health profession school from which the student had graduated with the course currently offered. "It's just beautiful" was the concluding comment. Another student noted that he had heard that the dropout rate from medical schools was 5% or less before coming to the course, "But just hearing you say it was very reassuring." Another student commented, "We're so far away from the center of things out here, we just don't get a chance to hear this kind of information."

Most students, when asked about the possibilities for increasing discussion participation, stated that they really knew so little about medical school and the medical profession generally, that it was difficult for them to realize that they would soon be in medical school, and difficult for them to visualize what it would be like. Hence a difficulty in formulating questions and comments. Comparison of discussion performance among different sections suggests an important additional factor: few students knew each other in these classes—the course itself was an unfamiliar situation. Active steps will need to be taken in future efforts in order to reduce this unfamiliarity.

## What of the Future?

The objective value of a course of this type is not easy to determine. Because students select themselves into this course, this voluntary participation aspect becomes confounded with possible effects of the course itself. Furthermore, the dropout rate from medical school is so low that this would not constitute a useful outcome evaluation variable. Perhaps the most useful approach would be to secure retrospective utility evaluations from student participants as their medical school education proceeds. This will be done:

At this point in time we find ourselves in the beginnings of an evolving project. Many changes and improvements can be undertaken, based on this initial experience. The course experience can be made more realistic, we think, by regularly tapping the first hand experience of students now in medical school, by arranging for them to be co-participants in the course. This was tried where possible during the past year, with good results. The entering student's spouse, fiance or special friend should be urged to participate. Course timing and teaching materials can be improved considerably. Equally important, there remain many yet-untapped sources for information input into the substantive course content in the literature, around the Baltimore Campus and among practicing physicians. Repeated cycles of experiment, evaluation and change should make possible a really effective introduction to a medical career.

## Acknowledgements

In addition to those persons noted previously, several others were very helpful in organizing the course. Dr. Ruth Kohl, then Associate Dean of the Nursing School, and Ms. Rachael Booth, Associate Director of Ambulatory Nursing Services provided helpful insights into the current nursing situation. Dr. Burton Pollack, Dr. Morris Roseman, and Ms. Rosalynde Soble, of Community Dentistry, provided information on that profession. Dr. John Young and Dr. David Knapp brought me up to date on the current situation in pharmacy. Dr. Richard Morton, Dr. Sherri Ferencz and Dr. Mary McDill contributed helpful advice on the organization and presentation of material. Mr. Richard Garlic of the Office of Medical Education provided essential help in organizing the teaching materials, and Ms. Leslie Borzamati prepared the illustrations. Col. Francis O'Brien, Executive Director of the Medical Alumni Association, provided essential liaison and evaluation.

*Editor's Note: The author is an Assistant Professor in the Department of Social and Preventive Medicine of the School of Medicine.*

# University of Md. Hospital Budget History—1924

*Ed. Note: This article is abstracted from Maryland Historical Magazine, Vol. 68, No. 4, Winter, 1973, "Albert C. Ritchie in Power: 1920-1927" by Joseph B. Chepaitis.*

"Governor Ritchie was essentially an economic conservative, and the entire 1924 Gubernatorial Message to the General Assembly, centering on a Democratic platform pledge to reduce the state tax rate by another three cents by 1927, was budgetary. This brought to more than nine cents the total state tax reduction accomplished during his first two terms.<sup>42</sup> The major struggle, in fact the sole conflict, of the 1924 legislature concerned increased appropriations for the University of Maryland and its hospital despite Ritchie's plea for budgetary restraint. The University of Maryland, since its enlargement by the 1920 legislature, had followed a policy of seeking continued expansion. In his January 4, 1922 Message to the General Assembly, Governor Ritchie opposed the University's desire to expand its facilities and to incorporate such institutions at St. John's of Annapolis, Washington College (Chestertown), and Western Maryland before the citizens of the state understood the implications of such plans. He questioned the wisdom of such a move when competent, private, small colleges existed in the state. The main purpose of the University, he thought, was its agricultural training. He countered the arguments of those who cited such state universities as Wisconsin by emphasizing that they were the only higher educational institutions in new Western states, while the East Coast had a proliferation of small colleges.<sup>43</sup> He also believed that Maryland would be better served by emphasizing elementary and secondary education for the many rather than '... higher education for the comparative few.'<sup>44</sup>

The University held that it too had a justifiable case. The Griffenhagen Report of 1921 had noted the many deficiencies of the University: desperate housing conditions, the poor fiscal condition of the schools of pharmacy, dentistry and medicine, dilapidated buildings (especially the antiquated Maryland University Hospital,) and an inadequate library, while the Governor's personally-appointed Committee on State Aid to Colleges expressed opposition to the University's enlargement. In conjunction with their disapproval, Gov-

ernor Ritchie in his 1924 Inaugural Address urged special aid for the small colleges of Maryland, such as St. John's and Washington College, to enable them to become self-supporting. He admitted that his budget provided for even less than the University's proclaimed essential minimum needs, but he believed that the amount allotted was the maximum the state finances could bear.<sup>45</sup>

Seeking legislative allies, the University of Maryland secured Senator Curran, still smarting from his defeat for the Presidency of the State Senate. He led the Senate anti-administration forces. The University and their political allies also prompted the alumni to bombard the Governor with telegrams and letters.<sup>46</sup>

Ritchie became piqued at attempts to increase his budget: "It is not an easy task to resist the demands that are being made upon the State Treasury, particularly when so many of the objects are worthy interests, but I feel that the State has about reached the point where, for the present at least, it cannot afford to take on much more."<sup>47</sup>

And,  
. . . after all ours is a common problem—the problem of fixing State expenditures at the point which will enable State affairs to be administered and State obligations to be performed with a union of efficiency, constructiveness and economy.<sup>48</sup>

He further asserted that public opinion, in his view, had not strongly supported the vast sums requested by the University—\$8,289,923 for the next three years.<sup>49</sup> His own University budget of \$2,849,600 for three years, he noted, provided for increases over past appropriations. He, therefore, notified the press that any additional sums above his own budget, even in the form of a loan, would meet with his prompt veto because it would increase the state's tax rate, which he had pledged to reduce. The issue was not his budget requests of \$2,849,600, which were accepted by the legislature, but additional sums.<sup>50</sup>

His foes seized on the disclosure that the University Hospital was a fire trap because it lacked fire escape stairs. Taking the offensive Senator Curran proposed that a new hospital be built. The Governor, however, began a counterattack with a bill to separate completely the Baltimore and College Park areas of the University by selling the Baltimore property, including the hospital, to private interests. In an unusual appearance before a joint session of the legislature on March 18, 1924, Ritchie acknowledged that he had committed an error in 1920 by approving the merger which put the University hospital and its allied schools under state control. He urged that only the Agricultural College at College Park remain under state super-

vision. The University hospital primarily benefited Baltimore City rather than the rest of Maryland. Moreover, he maintained, the counties did not profit by the medical school either because most of the graduates were from other states, and the majority of those from Maryland did not return to practice in the counties.<sup>51</sup>

Disregarding the Governor's plea, the Senate passed by 15-14 the Curran University Hospital bill of \$1,375,000, rather than Ritchie's proposal of \$400,000 in state aid for a new hospital and a separated University. The Governor's budget was also repudiated in the House in the final days of the legislature. The House defiantly passed four appropriations bills, totalling \$2,525,000, which were not included in the executive budget. Ritchie, charging that the Curran forces contemplated "putting him in a hole" by withholding final passage of the bills until the last days of the legislature to preclude any compromise measures, successfully vetoed the bills.<sup>52</sup> Fearing charges that inadequate funds were allotted for the University hospital, the Governor proposed a compromise of \$500,000 for the University hospital if the Board of Regents of the University agreed to a separation. In addition, Ritchie recommended that \$75,000 for fire escapes at the hospital should be raised by a bond issue which was later passed. The attempt at compromise for the building of a new hospital was stymied because of a refusal by the Curran forces to consent to the separation clause requested by Ritchie.<sup>53</sup> Nevertheless, he had maintained a balanced budget at the expense of the University despite strong pressures."

<sup>51</sup>Governor A. C. Ritchie, *Maryland: Governor Ritchie, Message, 1922-1931* (Baltimore, 1922-1931), pp. 1-39.

<sup>52</sup>Ibid., pp. 21-22.

<sup>53</sup>Ibid., p. 22.

<sup>54</sup>Ibid., p. 23; *Sun*, June 18, 1921, RS 41, p. 116; also see Griffenhagen, "Report . . . on the State Government," Part IV, vol. 1, pp. 174-205; James Petrie Rouleau, "The Governor of Maryland and Education, 1850-1950" (*Unpublished Master's thesis, University of Maryland*, 1951), pp. 76-77.

<sup>55</sup>*Evening Sun*, Feb. 2, 1924, RS 45, p. 54.

<sup>56</sup>A. C. Ritchie to Dr. D. C. R. Miller, Feb. 22, 1924, ACR (f.d. 15-a).

<sup>57</sup>Ritchie, *Message, 1922-1931*, p. 39.

<sup>58</sup>Interview with Walter N. Kirkman, July 30, 1964.

<sup>59</sup>*Evening Sun*, Feb. 2, 1924, RS 45, p. 54; *Sun*, Feb. 13, 1924, RS 24, p. 154; A. C. Ritchie to David G. McIntosh, Jr., President of the Maryland Senate, March 28, 1924, ACR (f.d. 15-a).

<sup>60</sup>*Evening Sun*, Feb. 19, 1924, RS 24, p. 173; Feb. 21, 1924, RS 45, p. 3; *Sun*, March 19, 1924, RS 24, p. 274; *Inaugural Addresses, 1920-1935*, pp. 9-11.

<sup>61</sup>*Sun*, March 26, 1924, RS 45, p. 25; March 28, 1924, RS 45, p. 37; *The Baltimore News*, March 28, 1924, RS 45, p. 32. The four bills were the Curran University of Maryland bill (\$1,375,000), the Roe-Towers Boulevard bill (\$375,000), the Salisbury Normal School bill (\$300,000), and the Allendale Institute bill (\$100,000). *Sun*, March 28, 1924, RS 45, p. 37.

<sup>62</sup>Ibid., p. 36; ibid., March 29, 1924, p. 39 and April 1, 1924, RS 45, p. 51; *The Evening Sun*, March 29, 1974, RS 45, p. 37. The hospital appropriation came in the 1927 legislature after the Governor had ascertained that the public wanted it. Interview with Walter N. Kirkman, July 30, 1964.

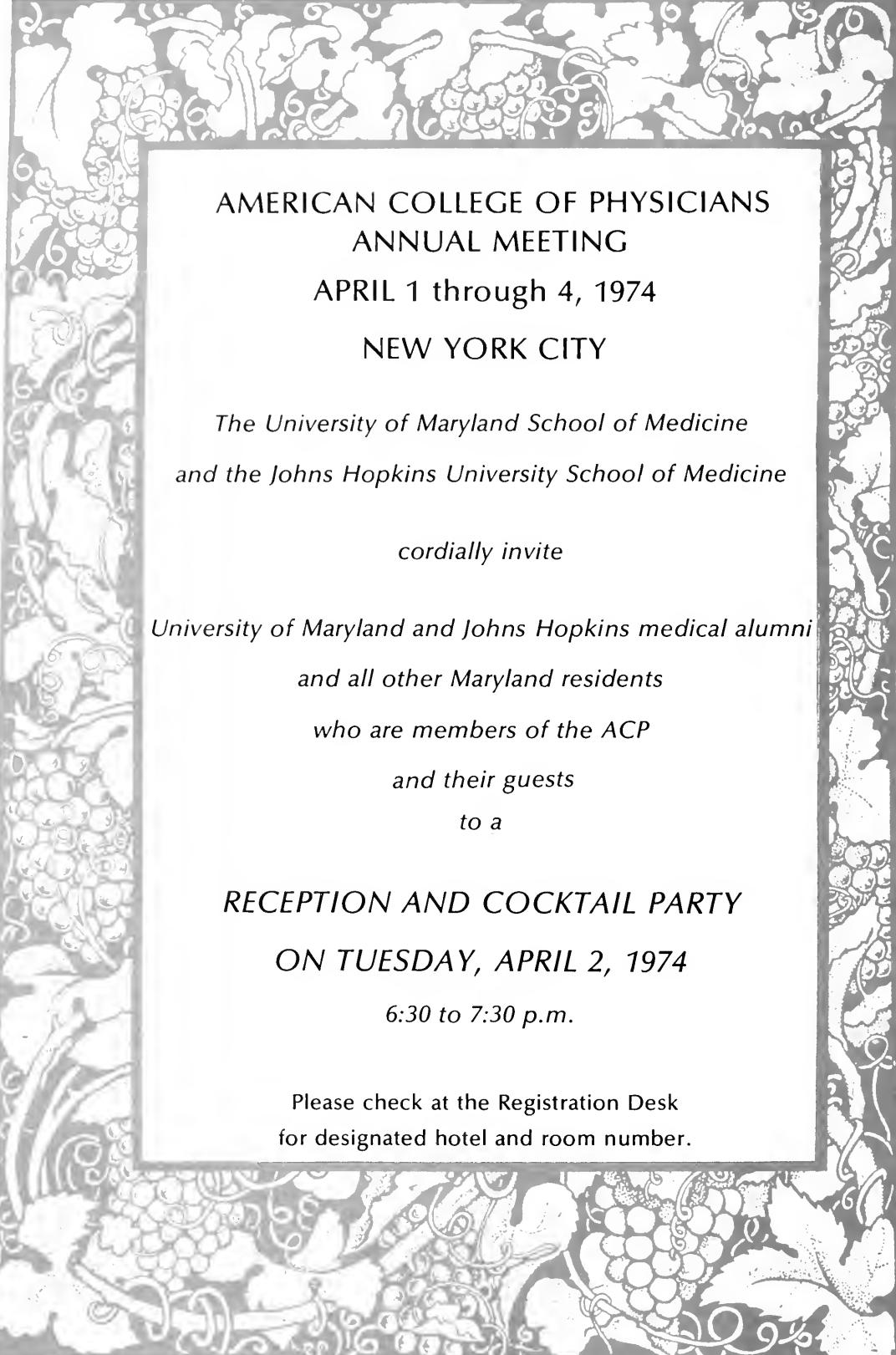
## ERRATUM

Omitted from Preceding Issue

### The House Staff as a Behavior System, Harris Chaiklin, P.H.D.

#### References

1. Hollingshead, A.B. Behavior Systems as a Field for Research. *Am. Soc. Rev.* 4: 816-822, 1939.
2. Norwood, W.F. Personal Lett. June 11, 1958.
3. Shryock, R.N. The Influence of the Johns Hopkins University on Medical Education. *Journ. of Med. Ed.* 31:226-235, 1956.
4. Shryock, R.N. The Unique Influence of the Johns Hopkins University on American Medicine. *Ejnar Munksgaard Ltd.*, Copenhagen, 1953, 60.
5. Huntington, M.J. The Development of a Professional Self-Image. In *The Student-Physician*. Ed. by R.K. Merton, G.G. Reeder and P.L. Kendall. Harvard University Press, Cambridge, 1957, 180
6. Chaiklin, H. *The House Staff of a University Teaching Hospital*, Unpub. Ph.D. Dissert. Yale University, 1960, 73.
7. Wessen, A.E. The Social Structure of a Modern Hospital. Unpub. Ph.D. Dissert. Yale University, 1950, 134-144.
8. Buerki, R.C. Problems of the Internship. In *Trends in Medical Education*. Ed. by M. Ashford. The Commonwealth Fund, New York, 1949, 136.
9. Mohler, W.C. Computers in Clinical Medicine. *Educom.* 8: 2-7, 1973.10. Walsh, J. Medical Evaluation: Design for a Comprehensive System. *Science.* 181: 1023, 1025-1026, 1973.



AMERICAN COLLEGE OF PHYSICIANS  
ANNUAL MEETING

APRIL 1 through 4, 1974

NEW YORK CITY

*The University of Maryland School of Medicine  
and the Johns Hopkins University School of Medicine*

*cordially invite*

*University of Maryland and Johns Hopkins medical alumni  
and all other Maryland residents  
who are members of the ACP  
and their guests  
to a*

**RECEPTION AND COCKTAIL PARTY**

**ON TUESDAY, APRIL 2, 1974**

*6:30 to 7:30 p.m.*

Please check at the Registration Desk  
for designated hotel and room number.

# Experiment in Chile

Muriel and Merrill Snyder

"Cuba, no esta sola (Cuba, you are not alone)," houted the signs in bold bright letters on the fences and walls as we drove along the wide avenues into the city of Santiago from Pudahuel airport. Our arrival, in November 1970 to begin a study of typhoid fever, was proximate to the recent inauguration of Salvador Allende as President of Chile. Although we had neither training nor experience in political science and economy, the opportunity was given us to observe first-hand the unique experiment of Marxism initiated by democratic election in this ribbon of a republic between the Andes and the Pacific.

Our hospital, the Infectious Disease Hospital, was typical of the city and its institutions. This four-story, 160 bed, yellow brick building located on the grounds of Barros Luco's Hospital, a large sprawling general hospital of the University of Chile School of Medicine teaching complex, was organized as a strict isolation acute care facility. The austerity of the physical plant and equipment was apparent immediately but this lack of sophistication was in contrast to the proficiency and dedication of the hospital staff. Initially a little resistance from some of the personnel to working with the "imperialistic Norte Americanos" was experienced but everyone was most courteous, friendly and helpful. And they had no end of patience. We spoke no Spanish and, except for the physicians, those who worked with us spoke no English. The hospital had only the rudiments of a laboratory, only minimal hematology and urinalysis were performed. The diagnostic bacteriology for this infectious disease hospital was performed miles away at the Bacteriologic Institute of Chile. The jovial cooperation and warmth of our laboratory assistants as we together uncrated and installed the equipment and prepared our media and reagents, communicating only by sign language and by Spanish-English dictionary, made the project fun indeed. Here was not the preconceived American image of the lassitude of tropical Latin America but industry and inventiveness concomitant with the temperate climate.

We found this attitude reflected in all whom we met as we traveled through the city. Santiago, on

our first trip, was unaffected by the election because Allende did not wish to disturb the status quo prior to the April elections for the House of Delegates. The only apparent changes were the political slogans that seemed to cover the city afresh each morning. The shops were filled with food, beautifully hand loomed fabrics, copper, onyx, jewelry and just about everything that one would expect to find in a large cosmopolitan city. Downtown was filled with well-dressed shoppers doing their Christmas shopping in the midst of summer. The only sign of shortages was the one meatless day each week in the restaurants—but how we remember those broiled thick steaks on the other six days.

We were impressed by the culture of Santiago. Newspaper kiosks were everywhere, sometimes three to a block, selling the current magazines from Germany and France as well as the dozens published locally and the 15 or so daily newspapers of Santiago, one or more for each political faction or party. Interestingly the only periodical representing the United States was the South American edition of Time. Bookstores abounded in the center of the city. Chileans came to both the beautiful opera and concert hall and the theater to hear the best music of Europe and Latin America and even some North American artists and orchestras. Plush movie houses with reserved seating were showing the latest American and European movies. Little theater groups were too numerous to count; one sponsored by the University of Chile was housed in a lovely little building. Supper clubs, discotheques, bistros and restaurants gave the city and its suburbs a cosmopolitan air. Best of all, the streets were filled with beautiful, very well dressed women, healthy children and fat, happy dogs and cats. Truly, Santiago and the surrounding countryside were beautiful, the mountains were always there, the climate was grand with warm days and cool nights, the seaside was only an hour and a half away and everywhere there was genuine friendship. Both of us speculated about Santiago being a delightful place in which to spend our future retirement.

The hospital was an ideal setting in which to conduct clinical research. The nurses and technicians considered it a matter of pride to follow protocol to the letter. The patients were cooperative and grateful for the care and attention they received. The ward physicians were kept informed by the camaraderie and close communication between themselves and the nursing staff. No visitors were permitted in patient care areas but every Thursday and Sunday afternoons the gates

to the grounds were opened. Visitors could climb the outside staircases to the balconies that ran along each floor and talk to the patients through the window ventilators. The only infractions that we observed were the passing of little notes between lovers or between mother and child through the narrow slots of the ventilator. The road in front of the hospital on visitors day became a fairground with itinerant street merchants peddling their ice cream cones, candies and gifts for patients. During the summer predominantly typhoid fever was seen. Patients came to the hospital early each morning and were admitted after examination until the beds were filled. Those who came later were examined, given drug and told to return if their symptoms worsened. Those who did not improve were given priority for admission when they returned. Although technology was primitive and the pharmacy was meager, the care to each patient was personal and considerate. If institutions can have a personality, our hospital wore a smile.

Politics was the main topic of conversation and the pro-Allende sentiments voiced by some of the affluent young professionals surprised us. Rumblings were beginning to be heard from the South but that was newspaper "talk" as far as our Chilean friends were concerned. Our three months there passed most happily and productively.

In July of 1971, I returned to a very different Chile. Elections were over; Allende felt he had the go ahead sign from the people—not as overwhelming as he would have liked but enough to justify his pushing on. Inflation had spiraled frantically. One night an evening paper announced a 300% rise in the price of medicines effective the following day. Coins became so scarce that you often received your change in merchandise. Commodities were becoming scarce and no effort was made to ration anything. It was winter and lines, blocks long, formed for propane and kerosene to fuel the household space heaters. Identification cards were issued to the citizens with their political affiliations recorded insuring by various subterfuges that the members of Allende's UP, Popular Unity Party, got priorities in the food distributions. The government in an effort to take over large factories created situations so that they could intervene legally in this most democratic country and take over the factory for the "people". Strikes were instigated deliberately with impossible salary demands. When management found itself unable to comply, the government appropriated the business in favor of the workers. Our young starry-eyed professional colleagues were becoming a little unsure of their

hero. Their disenchantment was hastened by the introduction of the teaching of Marxism in the elementary schools and the proposal that every school child at 10 years of age should spend a year working in a factory in order to appreciate the value of the worker. The hospital was to be governed by a committee chosen by the entire hospital staff. The director had to submit each decision for action to this committee which had a majority of members from the lower echelons of the hospital. Needless to say many directors of medical institutions were taking their retirement earlier than they had planned and the brain drain exodus was on.

The rapid deterioration of the political and economic situation was amazing. We wondered how far this could go. Our Chilean friends, both of the left and right, assured us that Chile, unlike the rest of South America, had a military which had a tradition of non-intervention in the internal politics of the country. When the news of the military junta reached us, we were shocked until we realized that this was the only way that Chile could be saved from the machinations of the extreme left. The physician's strike just before the junta took over provoked us to speculate as to the reaction of our medical community in a similar situation.

Recent letters from our friends express their approval of the military junta as best for their country. We find it difficult to understand, however, how a people who so prided themselves on their democratic personal freedom can put aside their way of life to overthrow the left. We still are naive enough to wonder if the means will be justified in the end. Chile is today a vastly different country than we found it three years ago. Our field trip turned out to be more instructive than we ever dreamed and we learned not only of typhoid fever but of the tenuous structure of political institutions.

*Ed. Note: Dr. Snyder is an Associate Professor of Medicine and Associate Director of the Division of Infectious Diseases, University of Maryland, School of Medicine. Mrs. Snyder accompanied Dr. Snyder on the trips and served as a volunteer laboratory assistant.*

# The Admissions Process—The Multitude of The Seventies

Karl H. Weaver, M.D.

The admissions process to medical schools in the United States can best be described by the phrase, "one of increasing competition". On a national basis, there has been a progressive increase in the number of applicants each year for at least the past 10 or more years and each year each applicant submits an increasing number of applications. This trend is shown in Table 1.

**TABLE 1**  
*Applications and Acceptances to Medical Schools in the United States  
(based on data of the Association of American Medical Colleges)*

Entering Year	Number Applicants	Applications Filed	1st Year Places	Percent of Applicants Enrolled
67-68	18,724	93,332	9,473	50.6
68-69	21,118	112,195	9,863	46.7
69-70	24,465	133,822	10,422	42.6
70-71	24,987	148,797	11,348	45.4
71-72	29,171	210,943	12,361	42.4
72-73	36,135	267,306	13,352	38.1
73-74	40,000*	288,000*	13,822	34.6*
74-75	43,000*	322,500*	14,300*	33.3*

*estimated*

The experience at the School of Medicine is a reflection of this trend on the national level as noted above. For the past number of years, the School of Medicine has received a varying number of applicants, but usually in the range of 1,800-2,200 for each year. However, the number of Maryland resident applicants within that number has increased tremendously, as is seen in Table 2.

**TABLE 2**  
*Applications to the School of Medicine*

Entering Year	Total Number of Applicants	Number of Maryland Resident Applicants	Number of 1st Year Places
66-67	1,038	160	101
.....	.....	.....	.....
66-67	1,758	270	128
67-68	1,914	324	136
68-69	2,102	365	139
69-70	2,106	428	144
70-71	2,266	508	144
71-72	2,231	694	155
72-73	1,945	725	155
73-74	1,752	808	155

The decrease in the total number of applicants is most likely the result of an active effort to discourage the non-competitive non-resident applicant from filing an application at the School of Medicine.

Not only has the number of applicants increased dramatically, but the strength of the credentials submitted has also had a corresponding increase

in strength. The objective characteristics of the entire applicant pool at the School of Medicine applying to enter in 1973 were such that the average over-all grade point average was above a B (3.00) level and the average Medical College Admission Test (MCAT) scores in each of the four sub-tests were at about the 50th percentile or slightly above.

For the past four years, the School of Medicine

has participated in the American Medical College Admissions Service (AMCAS), which is under the auspices of the American Association of Medical Colleges (AAMC). AMCAS performs some of the clerical processing and data collection relative to the applications, such as the evaluation of the academic transcript. After these clerical procedures are completed, the application is then sent to those AMCAS participating schools which have been indicated by each applicant. AMCAS also provides to the medical schools certain demographical, biographical, academic, and test score data in a machine readable form. For 1974, seventy five of the one hundred fourteen medical schools are participating in AMCAS. The AMCAS system has a number of advantages, some of which are: for the applicant, only a single application needs to be filled out and only a single set of transcripts requested (which are sent to AMCAS); for the medical schools, certain clerical procedures have been performed and certain data tabulated; for the medical community at large, a large statistical data base can be developed concerning not only the applicant pool itself, but also fractional parts of that pool such as those who are selected to enter, those who were not selected, and those who decided to follow other courses, etc.

It must be emphasized that AMCAS plays no role what-so-ever in the selection process. Each medical school makes its own selections by the criteria and mechanisms developed by that particular school which best suits its individual needs.

The School of Medicine uses the AMCAS application as the first of a two stage application process. Based on the information on the AMCAS application, which includes demographical, biographical, academic, MCAT score data, and personal comments by the applicant, a decision is made as to whether the second stage application material can be sent.

All applicants who can be identified as residents of Maryland or whose mother or father is a graduate of the School of Medicine are sent the second stage application material and are afforded the complete application process. The other applicants whose data do not indicate the possibility of being offered a place are so informed and told that the admissions process cannot be continued at the School of Medicine and are advised to direct their application efforts to other medical schools. By this mechanism, the applicant pool is reduced by approximately one-half, so that the School of Medicine is processing approximately 1,000 to 1,100 final applications each year.

The activities of the Committee on Admissions are actually year around ones, with the greatest

amount of activity being concentrated in the period September through mid-May. During that period of time, each member of the Committee spends approximately 8 to 12 hours a week at a minimum on the activities of the Committee. The Committee meets on a weekly basis during that time and each of the Committee members interviews a minimum of three applicants per week during the period of August through mid-March.

All decisions concerning whether the applicant is or is not able to be offered a place in the class are a result of these Committee activities. When an applicant's credentials are complete, the entire application folder with all supporting credentials is reviewed by the Committee. At that time, there is a complete discussion of all aspects of the application and all credentials submitted in behalf of it, and only then is a decision made by the Committee concerning that application. Consequently, each applicant has a complete, thorough, and equitable review by the entire Committee, with all resulting action being action by that entire Committee. The Committee presently has a membership of thirteen.

The Committee on Admissions feels that it must use as a touch stone against which their decisions are made, the competition which exists within the applicant pool. The applicant certainly must present evidence of his or her ability and willingness to achieve a high level of academic output as well as the ability to achieve on the nationally given objective test, the MCAT. It cannot be stressed too strongly, that the Committee considers of equal importance to demonstrated academic achievement, and competent test scores, the demonstration by the applicant of those personal attributes and achievements which it is felt all physicians should possess, including unquestioned honesty and integrity, acceptance and fulfillment of responsibility, leadership qualities, community and/or campus involvement and accomplishment, communications skills, and compassion, empathy and concern for one's fellow man. It must be added, that all applicants selected to be offered a place in the entering class possess all of these academic and personal characteristics at a very high level. Letters of evaluation from the undergraduate college and the personal interview are of utmost importance in the selection process, since they are a very good source of information concerning the applicant's personal attributes and motivation. No applicant is selected on the basis of only one or two parameters, be they personal or academic, if that applicant cannot demonstrate the possession of all the other characteristics also. Academic productivity and being a warm wonder-

ul human being are not mutually exclusive phenomena.

Because of the very large number of individuals applying to the School of Medicine, and because of the very large fraction of the applicant pool which is composed of Maryland residents, the Committee on Admissions is able to offer to only a very few non-resident applicants a place in the class, and those must possess truly outstanding credentials. For the past several years, with the Maryland resident applicants numbering in the high 600's to low 800's, the Committee has been able to select only a handful of non-resident applicants. For the past two years there have been a total of 6 non-resident applicants matriculating at the School of Medicine. In that period of time there have been a total of 310 matriculants, the class size having been increased to 155 places two years ago.

Because of the increasing strength of the credentials presented by the applicants, the objective characteristics of these classes selected have also increased. The competition is such that at this time the entering classes for the past several years have had an overall grade point average at the strong B+ level (3.50 or higher) and MCAT scores in the 70th-75th percentile. All other credentials, including personal attributes, have and are also at the same similar strength.

Looking at the class which entered in 1973 as an example, the following characteristics can be noted:

In a class of 155, 135 have a baccalaureate degree, 9 entered upon completion of the third year of college, and the remainder have a masters or a doctorate degree. For the past number of years, there have been 65 to 70 different undergraduate universities represented within the incoming class. The university represented by the largest number of matriculants is obviously the University of Maryland and there are usually about 35-45 of its graduates in each entering class. Biology and chemistry are the most frequently represented undergraduate major fields of study, but in addition the class also has represented approximately 25 undergraduate majors which range from aerospace engineering to zoology. The number of women and minority matriculants is increasing not only on a national level, but also at the School of Medicine, with 35 women in the class entering in 1973 and 16 minority matriculants.

For the past three years, the School of Medicine has participated in the coordinated transfer system (COTRANS). The COTRANS program is the mechanism whereby American citizens who have taken part of their medical education abroad can

return to an American medical school with advanced standing. In order to be eligible to participate, the applicant must be a citizen of the United States and must have completed the undergraduate experience in a college or university within the United States. At the School of Medicine, an applicant must also be a resident of Maryland and since the school is only able to accept transfers into the third year, the applicant must have completed that portion of the curriculum in the foreign medical school which comprises the basic science curricular experience. In addition, in order to be selected at the School of Medicine an applicant must have successfully completed Part I of the National Boards.

It is estimated that there are approximately 6,000 American citizens who are currently abroad in the foreign medical education system. The largest aggregates of American citizens are at the University of Guadalajara in Mexico and in the Italian medical schools. It is stated that there are approximately 1700 American citizens at the University of Guadalajara.

The School of Medicine also accepts transfer students from two year medical schools within the United States and other 4 year medical schools. The School is not able to accept, with advanced standing, individuals who have completed part or all of the curriculum of other professional schools such as dental schools, osteopathic schools, veterinary schools, etc. All acceptances for advanced standing are on a place available contingency, and all applicants who are selected must have demonstrated their academic competence and possession of the personal attributes as discussed above.

As can be seen, admission to medical school is highly competitive and there are many fine applicants who must be turned away because there is not a place available. Unfortunately, from the information from the undergraduate colleges, it would appear that the situation is going to become even more highly competitive over the next number of years, since an increasingly large percentage (figures of 60 to 70 percent not being uncommon) of incoming freshmen classes at a number of undergraduate colleges are stating medicine as being their career goal. My personal plea in this situation is that each of us work together in order to create a situation in which as many opportunities as possible are provided for those individuals who have demonstrated that they possess those characteristics which would permit them to make a substantial contribution to medicine.

*Ed. Note: Dr. Weaver is Associate Dean for Admissions, University of Maryland, School of Medicine.*

# The "Visiting Traineeship In-Service Program"

## 1966-1970

### The University of Maryland School of Medicine

E. T. Lisansky, M.D., M.A.C.P.

The implementation of this program at the University of Maryland School of Medicine was stimulated by an article written by Robert McFarland of Boulder, Colorado for the "Pharos of Alpha Omega Alpha" in July 1964. A paraphrase of what he wrote is as follows:

"Postgraduate education must be tailored to meet the need of the physician-students. One way to help the postgraduate student study what he feels is important, and at the same time, expose him to what others feel is important is to allow him to partake and join, for any reasonable length of time, the traditional residency training programs in teaching hospitals." He continued, "Most doctors would feel that 1 to 4 weeks a year in a refresher residency would give them much of what they want in terms of continuing education."

In February of 1965 the plan to develop an "In-Service Traineeship" was discussed by the Committee on Continuing Medical Education and it was unanimously agreed that this could be a significant and meaningful extension of the more formal, traditional postgraduate courses, and that this "Visiting Traineeship" should be added to the on-going established curriculum of continuing medical education. It was suggested that the Director of Continuing Medical Education write an explanatory letter of this tentative program to every department and division head, including those of the basic science departments. Every department and division head answered affirmatively and each, as requested, appended a weekly schedule of the undergraduate (medical school) and postgraduate (residency and staff) conferences of his particular department or division. The schedules of individual departmental and divisional conferences, rounds, etc. were gathered anew by the office of Continuing Medical Education, each summer, to correct for any curriculum changes in time, place, etc.

In March of 1965 this plan was presented to and unanimously approved by the Faculty Board of the

Medical School. An informative letter was written to the Intern-Resident Staff to acquaint them with this program and request their compliance, courtesy and cooperation. (This must be done anew each year after July 1st.) The Health Sciences Library personnel and the Director of the University of Maryland Hospital were informed of this program in order to solicit their approval and cooperation.

The following is an abbreviated outline of the program:

1. Each year an explanatory brochure with a detachable application questionnaire was sent to every physician in the state of Maryland.
2. This program was listed annually in the issue of the JAMA publicizing postgraduate activities.
3. Each year the Maryland State Medical Journal and the University of Maryland School of Medicine BULLETIN published a full-page information sheet covering the program.
4. The charge for each trainee was established as \$10.00 per day. The minimum enrollment time was set at one week—namely, 5 days, Monday through Friday.
5. After the application was received and the trainee tentatively accepted, he either visited or talked by phone with the specific department or division head concerned to clarify the schedule, appropriateness as to the timing of his visit, etc. These faculty members already had received a copy of all correspondence and the application blank previously sent to the office of Continuing Medical Education by the applicant. If geographical distance made a preliminary visit inconvenient, the applicant was advised to correspond directly with the department or division head so that both he and the faculty-host were assured of agreement.
6. Copies of all correspondence concerning every applicant was shared by the department head, the office of Continuing Medical Education and the applicant so that sources of error and misunderstanding were minimized.
6. The trainee was the "guest" of the head of a specific department or division of his choice. He was invited to participate, as actively as his own impetus allowed, in the routine schedule of rounds, clinics, conferences and lectures. He took histories, examined patients and participated in discussions concerning the decisions of diagnosis and management. His involvement and work did not replace the responsibility of the at-

tending and house staffs for the official work-up and the written orders on the chart.

7. Each applicant's curriculum schedule was individually designed and kept flexible; however, no alteration in the departmental routine was made to formalize this program into a specific postgraduate course. Allowances were made for cross-disciplinary visiting (for example, combining both rheumatology and cardiology or cardiology and bacteriology) where there was little conflict in the schedule of seminars, rounds, etc. In most instances, however, the trainee was immersed, for one or more weeks, in the work of one specific division, subject or medical problem.

8. Although the minimum enrollment was for one week (5 days), longer periods of traineeship were arranged for over 20% of the enrollees since the program began 4½ years ago. (See Chart I) These special arrangements were made with the approval of the office of Continuing Medical Education and the Head or Heads of the Departments or Divisions who would be host to the enrollee. Occasionally a trainee stayed for 2 to 4 weeks and divided his time between 2 to 4 departments or divisions.

9. Ample allowance of time was made for collateral reading in the privacy of the Health Sciences Library where the enrollee was assigned a private cubicle.

10. The enrollee was informed of and cordially invited to attend all guest lectureships, grand rounds and special professional meetings where it was appropriate and where he had an interest. He was informed of other medical meetings, lectures and seminars in other institutions in the city, away from the University Medical Campus where he might be interested in attending. Evening professional meetings of the Baltimore City Medical Society and the Maryland State Medical Society)

11. This program rarely accepted visits from trainees during the months of June, July and August except by special arrangement with a department head because the medical school program of education, faculty presence, and house staff experience is abridged during these summer months.

12. Thus, various departments, divisions and subdivisions of the University of Maryland School of Medicine and University Hospital were open to interested physicians through a "Visiting Traineeship In-Service Program" designed to expose the practicing physician to current concepts in the practice of medicine, surgery, pediatrics, psychiatry and their various subspecialties.

13. We hope this program offered a wide variety of possibilities that allowed a profitable and rewarding learning experience.

Certain points of information with reference to the host-faculty are as follows:

1. No division of the various medical school departments was expected to accommodate more than one visiting trainee at a time. Each division was not expected to have more than 5 enrollees during a specific scholastic year; however, this depended on the number of weeks each applicant stayed in any one division and how willing and able this particular division was to meet with an excessive application request. (See Chart III Cardiology)

2. The Chairman of the Committee on Continuing Medical Education assumed the responsibility of arranging any special traineeships in local affiliated hospitals or facilities when this learning experience was not available at the University Hospital. (Such as (1) Industrial-Occupational Medicine, (2) Geriatrics and (3) Rehabilitative Medicine in Chronic Disease.)

3. It was the responsibility of the Chairman of the Committee on Continuing Medical Education and his executive secretary to be available and responsive to the needs of the visiting trainee, arranging for appropriate hospitality, hotel rooms, etc. If possible, and when appropriate, the Chairman of the Committee on Continuing Medical Education, spent some time in cordial, social engagement with the trainee. This allowed for immediate feed-back from the trainee and a correction of any problems that may have developed in the implementation of the program.

4. It was found that an attitude of cordial receptivity by the division head and a corresponding attitude by his chief resident or fellow was the most important ingredient in the success of this program. We have been very fortunate in this regard since our faculty values teaching, learning and continuing medical education.

Ed. Note: Dr. Lisansky is a Professor of Medicine, Associate Professor of Clinical Psychiatry, and Associate Director of the Program of Continuing Education in the School of Medicine.

Presented to the Committee on Continuing Medical Education of the American Medical Association on October 14, 1970. Physicians from Maryland and throughout the United States have continued to visit the school of Medicine for the In-Service Traineeship Program. With the cooperation of the Medical School Faculty, the program will be given renewed emphasis in 1974-75. For further information, please write to Ephriam T. Lisansky, M.D., Associate Director, Program of Continuing Medical Education, University of Maryland School of Medicine, 29 S. Greene Street, Baltimore, Maryland 21201.



Dr. Ephriam T. Lisansky, Moderator, Dr. Willem Bosma, Director, Division of Alcoholism & Drug Abuse, Dr. G. Douglas Talbott, Medical Director, Baltimore Public Inebriate Program, discuss the clinical aspects of alcoholism.

## 4th Annual Md. Day Medical Alumni Conference

The 4th Annual Maryland Day Medical Alumni Conference was held at the Brunswick Hospital Center in Amityville, New York in October, 1973.



Dr. Robert T. Singleton, Associate Professor of Medicine and Co-Director, Cardiac Catheterization Laboratory, Dr. Ephriam T. Lisansky, Moderator, and Dr. Joseph McLaughlin, Professor and Head, Division of Thoracic and Cardiovascular Surgery, discuss cardiovascular disease and surgery.

Dr. Henry Startzman, Jr., Past President of the Medical Alumni Association and Dr. William Dunseath, President of the Medical Alumni Association, chat with Dr. Benjamin M. Stein, Brunswick President and Host of the Maryland Day Conference.



**FORTHCOMING CONTINUING EDUCATION OFFERINGS**  
of the  
**Program of Continuing Education**  
**University of Maryland School of Medicine**  
**29 S. Greene Street**  
**Baltimore, Maryland 21201**  
**Telephone: (301) 528-7346**

**PROGRESS IN DERMATOLOGY**

Harry J. Robinson, Jr., M.D., Course Director  
The Baltimore Hilton Hotel  
3:00 a.m. (7th.)-11:30 a.m. (9th.)  
March 7, 8, 9, 1974

Extensive discussions and presentations of common interest to dermatologists and internists will fill the days. Case presentations and discussions in the University of Maryland Hospital Dermatology Clinic will also be utilized.

Registration Fee: \$150.00

**CURRENT AND PRACTICAL NEUROLOGY  
FOR THE NON-NEUROLOGIST**

Erland Nelson, M.D. and Thomas R. Price, M.D.,  
Course Directors  
Hunt Valley Inn  
3:00 a.m. (24th.)-1:15 p.m. (26th.)  
March 24, 25, 26, 1974

This course is designed to present recent advances of diagnostic and therapeutic significance in Neurology for the practicing physician. The emphasis will be on the practical application of these developments.

Registration Fee: \$140.00

**VISITING PRACTITIONER PRECEPTORSHIP  
PROGRAM**

Ephraim T. Lisansky, M.D., M.A.C.P., F.A.P.A.,  
Program Director  
Individually designed programs of one or more weeks duration based upon the learning desires of the visiting practitioner.

Registration Fee: \$20.00 per day

**HUMAN SEXUALITY IN MEDICAL PRACTICE**

Sharon Satterfield, M.D., Course Director

Hunt Valley Inn  
3:00 a.m.-5:00 p.m.  
March 1, 1974

This course has been designed to present a developmental view of sexuality in a general medical setting. The instructors will stress the elements of determining normal behavior and the means of intervention in dysfunction. Throughout the day participants will have ample time for discussion with the instructors.

Registration Fee: \$50.00

**SELECTED TOPICS IN GENERAL AND FAMILY  
PRACTICE**

Edward J. Kowalewski, M.D., Course Director  
Allied Health Professions Building  
32 S. Greene Street, Room 201  
Baltimore, Maryland 21201

5:00 p.m.-7:30 p.m.

March 7/April 11, 1974—Six Thursdays

This course focuses on the common everyday problems with which the family physician deals. It also prepares him for the Family Practice Board Examination or recertification.

Registration Fee: \$50.00

**PSYCHOLOGICAL MANAGEMENT OF  
THE HANDICAPPED CHILD**

Marvin Cornblath, M.D., and William Seabold,  
M.D., Course Directors

The Baltimore Hilton Hotel

8:00 a.m.-4:00 p.m.

March 28, 1974

This course will review the psychological and social problems that face physically handicapped and mentally retarded children and their families. Emphasis will be placed on familiar counseling.

Registration Fee: \$35.00

**EMERGENCY MEDICINE—THE ROLE OF A SHOCK  
TRAUMA UNIT**

R. Adams Cowley, M.D., and William Gill, M.D.,  
Course Directors

Hunt Valley Inn

8:00 a.m.-5:00 p.m.

April 11, 1974

The role of a specialized facility such as the Maryland Institute for Emergency Medicine is discussed in the context of an emergency medical service. Numerous techniques and advancements in trauma will be presented. A tour of the Institute will be conducted following the conference.

Registration Fee: \$50.00

**INTERNAL MEDICINE—ADVANCES AND REVIEW**

Harold C. Standiford, M.D. and Morton I.  
Rapoport, M.D., Course Directors

The Annapolis Hilton Inn

10:00 a.m. (15th.)-5:30 p.m. (17th.)

April 15, 16, 17, 1974

Registration Fee: \$150.00

**CLINICAL REVIEW OF TRANSFUSION THERAPY  
AND BLOOD CLOTTING DISORDERS**

R. Ben Dawson, M.D., Course Director  
The Lord Baltimore Hotel  
8:00 a.m. (16th.)-5:00 p.m. (17th.)  
May 16, 17, 18, 1974

This course will review the transfusion management of shock; red cell transfusions; fresh frozen plasma platelets and white cells in transfusion therapy; and preventing hepatitis. Emphasis will also be placed on clotting test including work-ups, aspirin and its effect on the platelet; the treatment of hemophilia and bleeding in liver disease; and current concepts in the diagnosis and management of disseminated intravascular coagulation.

This intensive course has been designed to familiarize internists and medical practitioners with a broad spectrum of current developments in internal medicine. Speakers will emphasize new concepts and review relevant clinical material to facilitate problem solving and intervention in the care of patients.

Registration Fee: \$100.00

**VISITING  
PROFESSOR PROGRAMS**

**Sacred Heart Hospital**

*Calvin Y. Hadidian, M.D.—Coordinator*

March 20, 1974—Dr. Harold C. Standiford

“Newer Antibiotics”

“Antibiotic Combinations”

April 17, 1974—Dr. Bernard Shochet

“Managing the Difficult Patient in the General Hospital”

“Brief Psychotherapy in the Medical Office”

**Kent and Queen Anne’s Hospital**

*John S. Green, III, M.D.—Coordinator*

March 27, 1974—Dr. Frank LoGerfo

“Gastric Ulcer”

April 24, 1974—Dr. Sheldon Amsel

“A Planned Approach to the Diagnosis of the Anemias”

May 29, 1974—Dr. R. Ben Dawson

“Use and Abuse of Transfusions”

**The University of  
Md. Hospital  
Medical Board—  
A Profile**

*Richard S. Munford, M.D., President*

The proliferation of administrative organizations in a university medical school-hospital complex is such that an explanation of the functions and organization of the Medical Board of the University of Maryland Hospital is appropriate at this time.

The Medical Board is a standing committee of the School of Medicine Council and is invested with the executive power of the hospital's medical staff (455 active members). As stated in the medical staff by-laws (newly revised and becoming operative in July, 1972) “It shall be the responsibility of the Medical Board to continuously survey those features of professional service and hospital administration that affect the treatment and general welfare of the patients, the educational functions of the hospital, and to assist and advise the Director in the maintenance of the highest possible standards of care”.

The membership of the Medical Board consists of the heads of the thirteen clinical departments of the School of Medicine, six elected members of the active medical staff (four of whom shall always be selected from the part-time faculty) each of whom serve for two years, and nine ex-officio members (President of the Medical Staff, President-Elect, Secretary, Treasurer, Director of the hospital, Dean of the School of Medicine, the Chairmen of the Board's standing committees (8), President of the House Staff Association and a fourth year medical student selected by the School of Medicine Student Council.

The Board meets each month, except for July and August and special meetings may be called by the president or by petition of 25 members of the active medical staff.

Some idea of the areas of responsibility of the Medical Board can be gained from a review of its nine standing committees (Ambulatory Services, Credentials, House Staff Liaison, Infectious Control, Medical Records, Patient Care, Pharmacy and

Therapeutics, Tissue and Utilization). This, by no means exhausts the limits of the Board's functions since there are other vitally important, working committees which report on a rather regular basis at Board Meetings (Alcoholism and Drug Abuse, Blood Transfusion Practices, By-Laws, Cardiopulmonary Resuscitation, Emergency Room, Endowment Fund, Kidney Transplant and Dialysis, Medico-Legal, Nursing Service, Patient Admission Policies, Program, Research Liaison and Tumor Board). Many of these special committees have arisen to meet the demands of newly developed areas of hospital responsibility. These demands

can be expected to increase with passing time. Peer review, hospital accreditation standards and the recent introduction of PSRO are recent examples of areas which are requiring an increasing and major investment of time and effort by our medical staff.

This brief summary of the organizational structure of the hospital's Medical Board will serve, I hope, to introduce you to one of the mechanisms by which the staff is attempting to meet its responsibilities. It is a somewhat cumbersome mechanism and has succeeded to date only through the determined effort of many concerned and involved staff members.

---

# House Staff Association of University of Maryland Hospital

Louis A. Shpritz, M.D.  
President

For the University of Maryland Hospital's House Staff Association, as for the rest of University of Maryland Hospital, the big news of 1973 undoubtedly was the move from the old hospital to the new North Hospital of most of its vital functions as well as ancillary services. Along with this move, the House Staff moved most of its old quarters from those on the fourth floor of the Psychiatric Institute (more or less fondly remembered by the alumni) to the comparatively spacious, comfortable and modern area on the fifth and sixth floors of the North Hospital. The new House Staff Quarters represents culmination of years of cooperative planning by the administration and House Staff members.

Each room has its own climate control system and has two bunk beds with individual phones. In most cases, only two people sleep in each room. In addition, there are two television rooms, a reading room and a billiard room.

We feel that this vastly improved physical environment, added to an already fine educational program, will help attract many well-qualified applicants for House Staff positions.

Of course, we still face problems with the new Quarters, especially in the maintenance and se-

curity areas. However, we are gratified by a spirit of cooperativeness on the part of the administration in helping us solve these problems. We hope in the near future to not only solve these problems but also to make the Quarters a center for both House Staff communication and cooperation, in addition to its physical comforts. It is our sincere hope that this better communication and cooperation will contribute to improving patient care.

In the near future, the House Staff Association will speak through its representatives on the Faculty Senate (a recognition obtained one year ago) and the Medical Board with its many committees to become increasingly involved in improving patient care.

# A WORD FROM THE PRESIDENT

William J. R. Dunseath, M.D.

Is it possible that there are those among you who do not know which building is Davidge Hall? I was startled when one of our members wrote, several weeks ago, pointing out that Davidge Hall had already been torn down to make way for new construction on campus. Then it occurred to me that others of you who have been away from the scene for sometime might not associate the name Davidge with the building to which we keep referring.

It is true that up until the late 50's the old library on the south side of Lombard Street was known as Davidge Hall. This building was razed, and replaced with a new structure serving all the schools on the Baltimore campus, and known simply as "the Library." It was at this time that the designation "Davidge Hall" was applied to the structure on the northeast corner of Lombard and Greene Streets, apparently not previously named at all. This is the structure pictured on the cover of the Bulletin, the building which has come to be the symbol of the University of Maryland School of Medicine, the building around which the entire University of Maryland grew.

Progress in our restoration efforts is painfully slow, but it is being made. The last local hurdle has been cleared, and application is at last in Washington for entry into the Register of National Historic Places. Our campaign to raise the necessary funds is going just as slowly, but responses to our appeal are beginning to be felt. Hopefully the rolls of the Davidge Charter will fill the walls of the alumni lounge. If you have not already joined, send in your pledge now!

In other areas, the quest for a new dean presses on. Almost two hundred names have been put forward to the search committee for consideration. Several of these men have been invited to Baltimore and are impressive, but it should be noted that the man presently on the job is turning in an outstanding performance. John Dennis has the respect of everyone on the campus, and it is obvious he is not just doing a custodial job. Many of his priority decisions will reach well into the future. It will be difficult to find an outsider who will do better.

You will remember that a year ago Henry Startzman, who was then your president put out an earnest call for constructive criticism in an effort to stimulate interest in the association, and to increase its membership. The response was heartening, and some good points were advanced. We have been working since then on correcting some of the situations which stirred some of you to complain, and working also to implement some of the good suggestions. In an effort to get wider representation on the board of directors, Jim Roberts, '46 from Silver Spring, Maryland, and Miles Drake, '44, from Vineland, New Jersey are new members. Benjamin Stein, '35, and Herbert Berger, '32, both from New York are vice-presidents and have attended board meetings which are held each month on the fourth Tuesday. Tightening gasoline supplies may disrupt our plans and good intentions, but we hope to continue to widen our representation. Toward this end, if there is anyone outside the Baltimore area, but within reasonable distance who is willing to participate in this work, he is an excellent candidate for a position on the board of directors, and should make us aware of his willingness to serve.

Several letters expressed the wish for area activity. In some areas of the country there are active local groups of Maryland Medical Alumni, and, with a little effort, it is true that other areas might enjoy similar activity. Attempts are being made to stimulate such interest, and if any of you are particularly desirous of acting as area representatives, we can supply you with names and addresses of your fellow alumni in your areas. Some of you have already been contacted along these lines, and we will attempt to expand this policy.

Plans for Alumni Day are beginning to take shape as the Medical Alumni Association prepares to enter its 100th year. We are planning a change in location of the banquet, and hope to see a record number of alumni in attendance. Sam Donohue is this year's chairman, and, if his results equal his enthusiasm, the Day should be a huge success. Further information on this will be forthcoming through personal communications.

Alumni Day this year falls on May 30th. Reunion of five year classes is usually stressed, but there is no reason why all alumni cannot be welcome. Make your plans now to be in the Baltimore area and join us. We'll be looking for you.



## *DAVIDGE HALL IS A PRICELESS HERITAGE —SUPPORT ITS RESTORATION!*

The acoustics in Anatomical Hall have long been heralded. It may be that if one stands in a certain spot, and listens carefully, the voice of John Davidge himself is still heard reverberating. Perhaps we cannot truly restore the voices, but the hall itself is irreplaceable and cries for restoration.



Send your contributions now for this worthy project to Davidge Hall Restoration Fund, c/o Maryland Medical Alumni Association, 522 W. Lombard Street, Baltimore, Maryland 21201.

# **MEDICAL ALUMNI ASSOCIATION PROGRAM**

## **May 29, 30, 31, 1974**

**Wednesday, May 29**      Hospitality Reception and Registration  
Davidge Hall,  
8:00 P.M.

**Thursday, May 30**      **Alumni Day**  
Davidge Hall  
9:30-10:30 A.M.      Registration and Refreshments  
10:30 A.M.      Medical Alumni Assn. Business Meeting and  
                      Medical School Reports  
12:30 P.M.      Luncheon  
2:00-5:00 P.M.      Scientific Sessions  
                      The Bradley Pediatric Society  
                      The Douglass Obstetrical and Gynecological Society  
                      Institute of Psychiatry and Human Behavior  
                      University of Maryland Hospital Medical Association  
                      University of Maryland Surgical Society  
8:00 P.M.      Annual Alumni Banquet  
Main Ballroom  
The Baltimore Hilton

**Friday, May 31**      Pre-Commencement  
Civic Center  
10:00 A.M.  
  
3:00 P.M.      Commencement  
Civic Center

Detailed Programs will be available  
at registration desk

# NEW U. OF M. HOSPITAL CAFETERIA

*d Francis*

Following completion of Phase 1 of the cafeteria construction program, service has begun in the new Hospital cafeteria—long awaited by staff personnel. The new cafeteria employs the scramble system, wherein an individual does not have to wait in line if he does not want the item in that particular service area. Specifically, the cafeteria features two areas for salads and desserts, plus a third area for dinner salads and cold sandwiches, two areas for hot entrees, plus an added feature of hot sandwiches cut from steamship round of beef or baked ham. This is in addition to the usual hot sandwiches, soups, french fries, etc.

Additionally, improved service includes two full-service lines for hot and cold drinks. Two cashiers were found to be insufficient for the increase in customers and a third one has been added. The new airy, clean and relatively spacious cafeteria presently makes dining a noon day leisure in comparison to the acrobatic exercise it used to take to proceed through the line and find a spot in the old cafeteria.



*Staff, patients, and visitors enjoy a leisure meal in the new, attractive dining area.*



*Photographs by Phil Szczepanski*

*I-r Mr. Karl Dulichan, Mrs. Loretta Jones, Assistant Directors of Dietary Service and Mr. Bruce Thens, Director of Dietary Service host the Open House festivities.*

Sales in the new cafeteria have increased 22% since the move. Surprisingly, the breakfast meals have remained about the same. The noon and evening meals have increased 23% to 25% in numbers of customers served.

The new kitchen's special steam kettles have the water measured into them automatically. New convection ovens, stack ovens, braising pan, steamers, etc. coupled with the new preparation area, refrigerators, and receiving dock, now provide the facilities that were so desperately needed to provide the variety of meals one would expect to find.

Under Phase II of the construction, the dry provision storeroom, office space, pot wash and patient service area will be completed. On the cafeteria level the new flight-type dishwasher machine will be installed. Upon completion of the cafeteria the dining area will extend to the corridor. The area across from the present cafeteria will become a private dining room when not needed for overflow of customers from the cafeteria. The canteen service area will be enlarged to provide more variety of food for personnel when the cafeteria is not open.

Oil paintings on the wall have additionally enhanced the attractiveness of the cafeteria and the pleasure of dining. The dining area is separated into three distinct areas, two of which may be shut off by folding doors. This permits areas to be closed off to reduce the cleaning and/or provide private dining facilities.

*Ed. Note: Mr. Francis is Assistant Administrator of the University of Md. Hospital.*

# Nearby Historical Site Rests In Peace

Adjoining the campus next to Redwood Hall is a small plot of land covered with trees, evergreens and quiet pathways. On a sunny day it looks idyllic; a fine place for lunch or just sitting quietly.

From a distance.

Closer inspection reveals that the seats beside the paths are tombstones, some broken by vandal hands, others smoothly weathered by centuries of snow, rain, and frost. And the pathways are strangely thin . . . rat-width.

On a rainy, dark night the place would be a perfect setting for an Edgar Allan Poe story; appropriate enough, since the writer is buried just two blocks away, in the Westminster Churchyard.

Old Saint Paul's Graveyard, predating the UMAB campus by a generation or more, now lies forgotten and locked away, surrounded by the institution that some of its illustrious tenants once helped to endow.

At the end of the eighteenth century, when Baltimore City was considerably to the east, the area around the campus was suburban enough for Saint Paul's Parish to designate the property on Redwood Street as a graveyard, out of the boundaries of the "city" area.

Part of the prestigious parish for three centuries, the occupants of those crypts have names that sound like a Baltimore Baedeker: Hollins, Edmondson, Carey, Howard, Callender, Chase . . . and geography is not the only lesson the tombstones offer, but history as well.

There are tombs of colonial merchant princes, the squat mausoleum that houses the remains of John Eager Howard and a tilted headstone marking the grave site of Samuel Chase, a signer of the Declaration of Independence in '76 and revolutionary cum patriarch of the fledgling United States.

Frances Scott Key was there until 1860, along with Tench Tilghman, one of General Washington's aides, who "bore the tidings of the surrender of Cornwallis" from Yorktown to Congress in Philadelphia on October 23, 1781. Tilghman has also been removed.

Joseph Blankston possesses the state's oldest dated tombstone (1702), and George Ellison, a University medical student who died during the middle 1800's, is also there.

The giant cast iron gates are closed, and, as if to assure protection to the dead, a chain mail fence rises immediately behind it.

Someone has tried to liberate the brass plaque outside the gates—two of the bolts have been successfully removed. There are the scratch marks around the other two.

But there is talk in the community about saving the graveyard before there is nothing left to save at all.

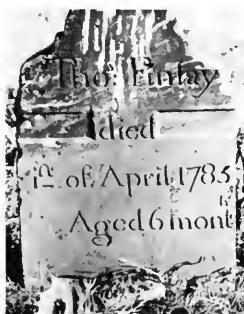
The acreage will be slightly cut by the new Fremont Boulevard, which will run parallel to the western edge of the campus. But neighborhood organizers in the Hollins Park area are actively interested in reclaiming the cemetery as viable greenspace in a part of the city where greenspace is at a premium.

Leland Cooley, radiation safety officer here and resident of nearby Hollins Street, and the Rev. Lance Gifford, a chaplain with the Ecumenical Campus Ministry at UMBC, have been active in keeping the community around the campus alive. Both would like to see the cemetery open and rejuvenated.

Opening the area as a park, they say, is perhaps the best way to preserve the historical and aesthetic value of the spot.

But, for the time being, little has been accomplished. The rats still run. The weeds still grow. The stones crumble. And, it can be presumed that the occupants of the graveyard don't care.

*Ed. Note: This article appeared in UMAB Happenings Vol. 3, No. 7, November, 1973, published by the Office of University Relations. Photography by Mr. Philip Szczepanski.*



# Faculty News

## New Appointments, Promotions and Resignations

Dwin Ezrine, D.D.S., Pedodontist—PEDIATRICS  
appointment effective 10-5-73) 2 Montaigne  
Court, Apt. #3A, Baltimore, Maryland 21208

Stanley Friedler, M.D., Instructor—SURGERY  
appointment effective 11-1-73) 4204 Milford Mill  
Road, Pikesville, Maryland 21208

Paul M. DeFigueirdo, Instructor—FAMILY PRACTICE  
(appointment effective 10-15-73) 2943 N.  
Charles Street, Baltimore, Maryland 21218;  
35-2321

David Heeren, Instructor—FAMILY PRACTICE  
appointment effective 7-1-73) 411 K Secluded Post  
Circle, Glen Burnie, Maryland 21061

Roger M. Miller, Assistant Professor—PATHOLOGY  
(joint appointment effective 10-8-73)  
0732 Faulkner Ridge Circle, Columbia, Maryland  
1044; 730-7929

Red N. Cole, M.D., Instructor—SURGERY (ap-  
pointment effective 1-1-74) 7322 Brightside Road,  
Woodbrook, Baltimore, Maryland 21212; 377-4344

Barbara Ann Plantholt, Research Associate—  
NEUROLOGY (appointment effective 11-28-73)  
018 Oakcrest Avenue, Baltimore, Maryland  
1234; 444-5093

William Dewey Blake, Professor and Chairman  
—PHYSIOLOGY (reinstatement after Sabbatical  
leave) 1211 Bolton Street, Baltimore, Maryland  
1217

Kirkland C. Brace, M.D., Research Associate  
Professor—RADIOLOGY (appointment effective  
1-1-73) 14 Savannah Court, Bethesda, Maryland  
20034

Arthur J. Lesser, M.D., Visiting Professor—  
PEDIATRICS (appointment effective 10-15-73) 2924  
Rittenhouse Street, N.W., Washington, D.C.  
20015; 244-5332

Stanford Friedman, M.D., Professor—PEDIATRICS  
(appointment effective 7-1-73) 484 Lymington  
Road, Severna Park, Maryland 21146

Thomas George Mitchell, Associate Professor—  
MEDICINE (appointment effective 9-1-73) 401 W.  
University Blvd., Silver Spring, Maryland 20901;  
393-3024

John Burling DeHoff, M.D., Associate—SOCIAL  
AND PREVENTIVE MEDICINE (appointment effec-  
tive 10-1-73) 112 Midhurst Road, Baltimore, Mary-  
land 21212; 377-6838

Kozo Murakoshi, M.D., Clinical Instructor—  
PEDIATRICS (appointment effective 1-1-74) 114  
South Rolling Road, Baltimore, Maryland 21228;  
788-6047

Fe T. Reyes-Dollete, M.D., Assistant Physician—  
PEDIATRICS (appointment effective 11-1-73)  
7505-T2 Valley Country Court, Baltimore, Mary-  
land 21208; 358-7216

John D. Barcik, Ph.D., Clinical Assistant Professor  
—PSYCHIATRY (appointment effective 11-1-73)  
104 Chestnut Hill Road W., Reisterstown, Maryland  
21136; 833-9430

Roger W. Byhardt, M.D., Assistant Professor—  
RADIOLOGY (appointment effective 11-1-73)  
10404 Faulkner Ridge Circle, Columbia, Maryland  
21044; 997-2119

Francis L. Carney, Jr., Ph.D., Clinical Assistant  
Professor—PSYCHIATRY (appointment effective  
11-6-73) 5500 Friendship Blvd., Apt. 2106N, Chevy  
Chase, Maryland 20015; 652-5807

Eugene S. Long, M.D., Clinical Assistant Professor  
—PSYCHIATRY (appointment effective 11-1-73)  
5620 Mirrorlight Place, Columbia, Maryland  
21045; 731-4531

Robert E. Wenk, Clinical Assistant Professor—  
PATHOLOGY (appointment effective 11-1-73) 2329  
Farrington Road, Baltimore, Maryland 21209;  
484-7283

Philip David Zieve, M.D., Associate Professor—  
MEDICINE (appointment effective 10-1-73) 3530  
Barton Oaks Road, Baltimore, Maryland 21208

Yale H. Caplan, Ph.D., Clinical Assistant Professor  
—PATHOLOGY (promotion effective 11-1-73) 8100  
Tapscott Court, Pikesville, Maryland 21208;  
655-2416

M. Wharton Young, Visiting Professor—AN-  
ATOMY (appointment effective 9-27-73) 3230 Park  
Place, N.W., Washington, D.C. 20010; 723-5150

Clark A. Rundell, Research Associate—PATH-  
OLOGY (appointment effective 12-2-73) 15709  
Oursler Road, Burtonsville, Maryland 20730;  
421-9432

Kulwant Ahluwalia, Instructor—PEDIATRICS  
(promotion effective 12-1-73) Apt. A3, 6716  
Havenpark Road, Baltimore, Maryland 21237;  
391-2661

W. Montagne Cobb, Visiting Professor—ANATOMY (appointment effective 9-24-73) 1219 Girard Street, N.W., Washington, D.C. 20009; 202-265-7775

Paul Mendonca, Research Associate—SURGERY, resigned 12-31-73

Ronald L. Paul, Assistant Professor—SURGERY, resigned 12-31-73

Suketami Tominaga, Associate Professor—PREVENTIVE MEDICINE, resigned 12-29-73

Mary E. Krum, Associate—PREVENTIVE MEDICINE, resigned 12-29-73

Ajaib Sidhu, Medical Consultant—PSYCHIATRY, resigned 1-9-74

Cicely Williams, Visiting Professor—PEDIATRICS, resigned 12-1-73

Fe T. Reyes-Dollete, Assistant Physician—PEDIATRICS, resigned 1-1-74

Dennis Brown, Associate Professor—CELL BIOLOGY & PHARMACOLOGY, resigned 7-6-73

Richard L. London, Assistant Professor—PEMATRICS, resigned 11-3-73

Bernard Thompson, Research Assistant—BIOCHEMISTRY, resigned 11-24-73

Thomas W. Smithson, Ph.D., Research Associate—INTERNATIONAL MEDICINE, resigned 12-27-73

Cornelius Barry, Assistant Professor—INTERNATIONAL MEDICINE, resigned 12-31-73

Albert Goldberg, Associate Director—DEAN'S OFFICE, resigned 1-1-74

Richard Garlick, Assistant—DEAN'S OFFICE, signed 1-1-74

Marianne Schour, Assistant Professor—PEMATRICS, resigned 12-31-73

Mary E. Manzo, Research Assistant—PREVENTIVE MEDICINE, resigned 10-12-73

Peter P. Cresci, Administrative Assistant—FAMILY HEALTH CENTER, resigned 12-18-73

## ALUMNI CHATTER

*Dr. Nevins W. Todd, Jr., grandson of the founder of Peninsula General Hospital, Salisbury, Maryland, became chief of the Medical Staff of that institution, effective January 1.*

Dr. Todd, a prominent surgeon, heads a new slate of officers as the hospital enters a decisive stage in its 76-year-old history. A massive redevelopment program is in the offing, with difficult decisions facing medical staff and trustees alike.

Other new staff officers are Dr. Joseph H. Cutching, Jr., vice-president; Dr. Louis H. Himes, II, secretary; and Dr. James H. Norton, treasurer.

This quartet is the youngest, in recent history at least, to lead the staff. Dr. Todd, at 41, is the eldest of the group. He takes over the presidency from Dr. Raymond M. Yow, who served two years.

Dr. Todd's grandfather, Dr. George W. Todd, was even younger, however, when he obtained a charter and opened Peninsula General Hospital for business in 1897. Dr. George Todd was but 36 at the time. For a considerable number of years he directed both the medical and business affairs of the hospital.

But whereas in the early days the medical staff consisted of a handful of men, there currently are 86 members on the active staff embracing 20 or more special fields of medicine.

Asked what his administration would strive for, Dr. Todd replied: "Unification."

"Our principal goal," he said, "will be to bring about an even greater unification of effort by the medical staff toward overall improvement of medical care, including constructive recommendations to insure that the medical staff will make significant input into planning for new hospital facilities."

"We have a great many dedicated and devoted trustees—remember, they serve without pay—and I hope we can unite all our efforts to attain a common goal which will benefit the entire community we serve."

Dr. Todd was graduated from Wicomico High School in 1950, attended Syracuse University and received his medical degree from the University of Maryland School of Medicine in 1957. He stayed at University of Maryland Hospital for his internship and six years of graduate work in general and thoracic surgery. He is a specialist in both thoracic and cardiovascular surgery and in the past two years has devoted considerable time to study and training in heart and lung surgery.

Besides being a member of county, state and national medical associations, and a half dozen specialty groups, Dr. Todd is active in commun-

ffairs including Wicomico Presbyterian Church, Boy Scouts, Heart Association of the Eastern Shore, and the American Lung Association of the lower Eastern Shore. He is a member of the Rotary and Elks Clubs and a founder of the Salisbury Ski Club.

When he came to Salisbury in 1966 he joined the surgical team of Long, Briele, Hughes and Todd, which now also includes as associates, Drs. V. S.ao, David P. Largey and Andrew J. Forgasch. Dr. odd also is medical director for Dresser Industries here.

• • •

*Cornell University President, Dale R. Corson has announced the founding of The Aaron Feder Visiting Professorship in Medicine established by Morris Brecher. Its first holder is Dr. W. Proctor Haney, Professor of Medicine and Director of Cardiology of the Georgetown University Medical Center.*

Mr. Brecher established the Professorship in honor of his dear friend and physician, Dr. Feder, Clinical Professor of Medicine, CUMC. Mr. Brecher is a realtor and noted philanthropist. A founder of Albert Einstein Medical College, Long Island Jewish Hospital, and the Boys Club of Queens, he is also active in the United Jewish Appeal, Federation of Jewish Philanthropies and the American Friends of Hebrew University in Jerusalem.

Dr. Aaron Feder Visiting Professorship in Medicine established by Morris Brecher brings to the Medical College each year a distinguished scientist or physician as visiting professor in the field

of internal medicine. An annual contribution from Mr. Brecher provides for an honorarium and appropriate amenities for the visiting professor.

Dr. Feder graduated from the University of Maryland School of Medicine in 1938.

• • •

*Frank J. Ayd, Jr., '45, Baltimore, Md., was made a corresponding member of the Australian and New Zealand College of Psychiatrists, Sydney, Australia.*

This decision, ratified by the Annual General Meeting of the College, had been recommended by the Executive.

A College spokesman said Dr. Ayd, Director of Professional Education and Research, Taylor Manor Hospital, Ellicott City, Maryland, had become widely known to College members.

Dr. Ayd addressed the 1973 International Congress, gave a paper on "Recognition and Treatment of the Depressed Adolescent" and gave numerous television, radio and newspaper interviews to do with suicide, depression, and the treatment of the depressed patient.

• • •

*Michael J. Haney, '66, has been certified by the American Board of Surgery and is in the private practice of general and vascular surgery in Myrtle Beach, South Carolina. Dr. Haney completed his residency in surgery at Emory University Hospitals in Atlanta, Georgia, and served two years with the USAF as surgeon and Chief of Surgery at the USAF Regional Hospital, Shaw AFB, South Carolina.*

# ALUMNI NEWS REPORT

## TO THE BULLETIN:

I would like to report the following: -

## **SUGGESTIONS FOR ITEMS**

- American Board Certification
- Change of Office or Address
- Residency Appointment
- Research Completed
- News of Another Alumnus
- Academic Appointment
- Interesting Historic Photographs and Artifacts
- Scientific Articles

Name \_\_\_\_\_

## Address

## Class

Send To: George H. Yeager, M.D.  
Editor, Alumni Bulletin  
University of Maryland  
School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Maryland 21201



University of Maine Island S

editorial board

George H. Yeager, M.D.  
(*editor*)  
Mary A. Lantz  
(*editorial assistant*)  
George Entwistle, M.D.  
Robert B. Goldstein, M.D.  
Donald T. Lewers, M.D.  
Joseph S. McLaughlin, M.D.  
Frederick J. Ramsay, Ph.D.  
Elijah Saunders, M.D.  
W. Douglas Weir, M.D.  
John M. Dennis, M.D.  
(*ex-officio*)  
William J. R. Dunseath, M.D.  
(*ex-officio*)  
Jack C. Robinette  
(*ex-officio*)

# Bulletin

**university of maryland school of medicine**

May, 1974

Vol. 59

No. 2

*February and May cover photographs by Robert O. Torrence.*

The Medical School Curriculum	2
The Addition to John Eager Howard Hall	5
The Office of Medical Education	7
The Baltimore Cancer Research Center	8
The Changing Faces of Dental Education	10
The Graduate School—UMAB	13
The Newest School on Campus	16
Changes in Pharmacy at U. of Md.	19
A Word from the President	20
Faculty News	23
Alumni Chatter	25
Medical Alumni Association Programs	27
Alumni News Report	32

# Officers and board of Directors of the Medical Alumni Association

1973-74

## PRESIDENT:

William J. R. Dunseath, M.D. '59

## PRESIDENT-ELECT:

Robert B. Goldstein, M.D. '54

## SECRETARY:

Joan Raskin, M.D. '55

## TREASURER:

John F. Strahan, M.D. '49

## VICE-PRESIDENT:

Herbert Berger, M.D. '32

## VICE-PRESIDENT:

Benjamin M. Stein, M.D. '35

## MEMBER EX-OFFICIO:

John M. Dennis, M.D. '45

## MEMBER EX-OFFICIO:

Edward F. Cotter, M.D. '35

## MEMBER EX-OFFICIO:

Henry H. Startzman, Jr., M.D. '50

## MEMBERS OF THE BOARD:

Joseph S. McLaughlin, M.D. '56

Salvatore R. Donohue, M.D. '64

Aristides Alevizatos, M.D. '60

Eugene J. Riley, M.D. '44

Joseph D'Antonio, M.D. '46

James A. Roberts, M.D. '46

Herbert J. Levickas, M.D. '46

David R. Will, M.D. '43

Elijah Saunders, M.D. '60

# Information for Contributors

CONTRIBUTIONS: Original typed copy, not carbon copies, and illustrations, requests for exchanges and book reviews, should be forwarded prepaid at the author's risk to the Editor of the University of Maryland School of Medicine Bulletin:

George H. Yeager, M.D., Editor

Alumni Bulletin

University of Maryland School of Medicine

Room 107 Gray Laboratory

Baltimore, Md. 21201

PREPARATION OF MANUSCRIPTS: Manuscripts, including references, should be typed double spaced on one side of the paper, leaving wide margins. While every effort will be made to guard against loss, it is advised that authors retain copies of manuscripts submitted. All pages should be numbered. Numbers one to ten should be spelled out, except when used for all units of measurement (time, dimension, degrees, weight, volume, dosage, etc.), percentage, and decimals; for numbers above ten, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized. Units of measurement, e.g., dosage, should be expressed in the metric system. Temperature should be expressed in degrees centigrade. Contribution in a foreign language, when accepted, will be translated and published in English.

PREPARATION OF ILLUSTRATIONS: Black and white illustrations will be reproduced free of charge, but the publisher reserves the right to establish a reasonable limit upon the number supplied. Colored illustrations will be published at the author's expense. Black and white photographs should be presented as glossy prints. Line and wash drawings should be black, on white paper, with lettering in black India ink, large enough to be readable after necessary reduction. Large or bulky illustrations should be accompanied by smaller glossy reproductions of the same, to facilitate their circulation among the judging members of the editorial board. Illustrations should be numbered, the tops indicated, and the author's name and the title of the article in brief should appear on the back. A separate typewritten sheet of legends for the illustrations should be supplied.

REFERENCES: A bibliography of numbered references in alphabetical order should appear at the end of the manuscript with corresponding numbering in the text. Bibliographies should conform to the style of the Index Medicus with the exception that the last page number should be omitted, viz: author's name, title of article, name of journal, volume number, first page number, and year of publication in the order named.

## INFORMATION FOR SUBSCRIBERS

The University of Maryland Medical Alumni Association Bulletin is the official publication of the University of Maryland Medical Alumni Association and is published jointly four times annually by the University of Maryland Medical Alumni Association and the Faculty of the University of Maryland School of Medicine. Subscription price is \$5.00 per year in the United States, Canada and Mexico; and other countries \$6.00. Single copies, current and back copies, if available, are priced at \$2.00.

CHANGE OF ADDRESS: Please allow 60 days before date of issue for change of address. Notification should include the old as well as the new address (include Zip Code) with indications of whether the change is temporary or permanent. Please give the name of the journal. Copies will not be replaced without charge unless we receive a request within 60 days of the mailing in the U.S. or within 90 days in all other countries.

Membership subscriptions (University of Maryland Medical Alumni Association) and business relating to membership should be sent to: University of Maryland Medical Alumni Association, University of Maryland School of Medicine, Room 201 Davidge Hall, 522 W. Lombard Street, Baltimore, Maryland 21201.

The Publishers accept no responsibility for opinions expressed by Contributors.

# THE MEDICAL SCHOOL CURRICULUM

## A Brief Recent History and Present Status

*Joseph S. McLaughlin, M.D.*

"It is my, perhaps prejudiced, conviction that Medicine is the only profession that gives unlimited opportunities for combining the richness and the joys of both the scholar and the humanist. And it offers the broadest spectrum of potential relationships between man's accumulated knowledge and his heart."<sup>1</sup>

During the past fifteen years medical colleges throughout the country have been examining, evaluating and in some instances radically changing the programs presented to their students. The reasons for this educational upheaval are many. There has been a volumetric expansion of medical knowledge, keeping pace with the enormous expansion of science in the post Second World War period. The notion that all problems large and small, from putting a man on the moon to curing cancer, can be solved by research has been the impetus to this scholarly expansion. Only recently has this concept been re-examined when it became apparent that not all problems are immediately solvable despite enormous outlays of money and the even more recent realization that our resources are limited and priorities must be established. One may note the forces created by an increasingly scientifically educated student body and the need to accommodate those technologically better educated persons. Simply stated, much of the basic subject matter taught in medical schools a generation ago now is presented in college and in some instances in high school, not to mention the amount of scientific data now "common knowledge" because of the greater scientific information base of our society. Further the practice of medicine was changing. Specialization was the usual course following graduation. Group practice and partnerships were becoming more popular and the general practitioner was a vanishing breed. (We are coming full circle on the latter.) This rapid change in the social structure and scientific base of our society required a constant reappraisal of subject matter on

an individual instructor and departmental basis. Since such appraisal was occurring in all departments, efforts to communicate and correlate the results of these appraisals took the form of curriculum committees. Such a committee has been in existence at the University of Maryland for dozen years.

A decade ago the curriculum at the University of Maryland School of Medicine was structured along the classic lines recommended by Flexner. Essentially the first two years were basic sciences taught in a lecture-laboratory format. There was little integration of the clinical sciences into these programs. The major contribution of the clinical sciences was a course in physical diagnosis presented during the second semester of the sophomore year. The junior year was a ward rotation with the student spending time as a junior clerk in the various clinical disciplines. The senior year was similar—the student served clerkships in those disciplines which he had not encountered during the junior year and additionally served more advanced clerkships within the Departments of Medicine, Surgery, Pediatrics, and Obstetrics and Gynecology. At that point in time straight internships were becoming more popular, but most students still opted for rotating internships before beginning a specialty residency.

The curriculum committee organized a series of faculty assemblies during which the various problems being encountered in medical education were discussed. From these meetings a series of recommendations were developed which lead to a change in the format and content of the first two years. Essentially the basic disciplines were retained but were modified to allow an increased presentation of clinical material. Anatomical laboratory time was reduced and less emphasis was placed on individual laboratory experience in biochemistry and physiology. The subject systems approach was utilized to introduce clinical material. This is a program using pathology as a base in which clinical problems are discussed in an introductory manner during the pathologic con-

deration of the various systems. For example, during the microscopic and gross pathological examination of the respiratory system, basic physical examination of the chest is presented by the internist, basic radiology is presented by the radiologist and clinical pathology takes the form of a consideration of blood gases and pulmonary function tests. These programs are designed by a committee of persons representing the various disciplines. Each committee has a chairman who in turn represents that committee on the Subject Systems Committee proper. In general this committee structure has functioned well. Most of these programs have been well-received by the students and the faculty and there seems little doubt that this integrated program presents those aspects of basic science and basic clinical science deemed by consensus to be the most crucial. The latter consideration is an important one in view of the large amount of knowledge which is available in any one area.

Approximately five years ago, again after numerous faculty meetings and long, and at times difficult, consideration, the clinical years program was altered. The alteration was based upon the fact that medicine is an exceedingly broad field and granting that a basic education and introduction to all of the clinical disciplines is desirable, differences in careers requires a difference in individual educational patterns. Thus, an elective program was developed for the senior year. Also included in the senior year was a program in ambulatory medicine. During the preceding years less emphasis had been placed on the outpatient department as a means of medical education. This, despite the fact that most patients encountered during one's professional life, are seen on an outpatient basis. Programs in ambulatory care were established within the University of Maryland Hospital environment and by affiliations with community hospitals as far distant as York, Pennsylvania and in the offices of local physicians representing many disciplines.

More recently a number of programs and modifications of existing programs have been undertaken by the various departments, who noting a need have sought to fill this need. For example, there are "tracting" programs in pediatrics, psychiatry, and family medicine, joining a similar long operational program in medicine. These programs introduce a student to these disciplines

as early as the freshman year and utilizing free time and the elective structure assist the student to advance his knowledge in a particular area. One may think of these as majors; the student, while receiving the usual education presented to all students, is able to acquire considerable expertise in a specific area. Tracting programs have worked quite well and increasing numbers of students have availed themselves of the opportunities presented. Additionally, there has been an increase in the amount of clinical material introduced into the first year of medical school. Basic science—clinical science programs involving anatomy, biochemistry and physiology have been developed and are formalized under the title of Correlative Medicine. Clinical problems relating to the basic science area currently being covered are considered. For example, during the physiologic consideration of cardiovascular dynamics the basic laws of flow are correlated with the clinical findings in a patient with peripheral vascular disease.

Alternatives to the lecture technique in both basic and clinical science have been explored and generally have taken the form of audiovisual self-teaching programs. As an educational experiment, physiology is being presented in three forms: a classic lecture series, a laboratory experience combined with selective readings and a pathophysiologic presentation combining the expertise of the clinical and the basic scientist. These alternatives have been developed for a number of reasons, primarily to give students with different learning capabilities the opportunity to study and learn in a situation which best suits his or her talents; but also to provide a more efficient educational system for ever increasing numbers of students.

**Recent Developments:** For the past two years the Curriculum Committee through a committee structure involving some 70 members of the faculty, house staff and student body have undertaken a reappraisal of the total curriculum structure. It is apparent that much of the curriculum is well-structured and well-presented and equally apparent that there are certain shortcomings in the basic educational process and in the structuring of the courses.

The basic makeup of the Curriculum Committee, that is, seven members of the faculty with no administrative function, only powers of recommendation to the faculty board, was deemed insufficient to cope with the many aspects of the educational process. Wider representation of the

faculty and particularly of the various levels of the academic program was sought. Therefore, it was recommended that committees representing each academic year be formed and that these committees in turn relate through a chairman to the basic Curriculum Committee. Additionally, it was recommended that an Office of Medical Education be established. In a broad-based curriculum many developmental and administrative tasks must be carried out and coordinated, including such diverse functions as the formulation of schedules, the development of elective programs, and the development of teaching methodology, including audiovisual aids and the use of television networks. These major changes maintain faculty, as opposed to administrative control of the curriculum, but provide an administrative structure to cope with ongoing problems outside the educational and scientific domain.

The elective program which had extended into the earlier years of the medical school was placed on a formal basis. Further the elective program in the senior year was placed under more constraint. While many of the elective courses were outstanding, some were of no particular educational value. Additionally, it was felt that with an ever increasing student body, at least some portion of the senior year should be spent in an area of clinical responsibility which was clearly identifiable and clearly identified the student within the area. Bigness produces anonymity and this ensures that at least one faculty member is intimately aware of each student's abilities and progress.

Finally, a committee was established to examine the entire area of evaluation. Space does not allow a discussion of the many facets of this process, but certain problems are apparent. How does one rank students? Indeed, should they be ranked? Are there mechanisms to compare our students' education with the education of students in other universities? What constitutes an adequate education? Is it too long as many imply or is it too short in this age of increased knowledge? These and other questions must be examined if we are to perform our function of educating future physicians.

Curriculum is constantly evolving. Not only is subject matter constantly changing in a constantly changing world, but the philosophic implications of a medical education are changing as well. What is the role of the University of Maryland School of Medicine? Is it a school for family practitioners or is it a University, carrying on scholarly activity for the production of multipotential physicians, both family practitioners and various specialists? Most would feel that the latter is the correct major goal

of our institution. Curriculum reflects the thoughts and philosophies, and the philosophies reflect the times in which we live. Certainly and perhaps most importantly the major purpose of curriculum is to prepare the medical student for his life in medicine, not only in an academic sense but in an emotional and cultural fashion as well. Such lofty purpose requires constant effort if we are to approach the ideal.

*Ed. Note: Doctor McLaughlin is Professor and Head of the Division of Thoracic and Cardiovascular Surgery. I has served on the Curriculum Committee of the University of Maryland School of Medicine for the past five years and was chairman of the committee during the past two years, during which time a complete re-evaluation of the educational process was carried out.*

1. Atchley, D. W., *The Uses of Elegance, Address delivered at the Gold-Headed Cane Ceremony, University California School of Medicine, San Francisco, on June 1 1959*

## "ABOUT TOWN"

### Changing Events & Exhibitions

Preakness Day (Pimlico Race Track) 9:00 a.m. to Dusk—Saturday, May 18, 1974

Baltimore Museum of Art  
Art Museum Drive-889-1735, Tuesday-Friday  
11:00 a.m.—5:00 p.m.; Saturday 10:30 a.m.—5:00 p.m.; Sunday, 1:00 —5:00 p.m.  
March 19-June 2—White Collection  
April 16-May 26—The Hans Popper Collection of Oriental Art  
April 23-May 26—Walter Gropius  
April 30-June 30—Homage to Jacques Lipchitz

Morris Mechanic Theatre  
Charles Center 685-2624, Monday-Thursday 8:00 p.m.; Friday & Saturday 8:30 p.m.  
May 27-June 8 "Seesaw"

### CONTINUOUS EXHIBITIONS

\*Baltimore Streetcar Museum  
1900 bl. Falls Rd.—727-9053, Sunday 1-5 p.m.  
Collection of cars showing the evolution of the streetcar in Baltimore from 1880-1960.  
Rides available on antique streetcars.

\*U.S.F. Constellation  
Constellation Dock, Pratt St.—539-1797  
Monday-Saturday 10:00 a.m.-4:00 p.m.; Sunday, Noon-5:00 p.m. Launched in Baltimore in 1797 this historic vessel was the first ship of the U.S. Navy.

\*Of special interest to children.

*Courtesy of the Visitors Information Center, Baltimore Promotion Council.*

# THE ADDITION TO JOHN EAGER HOWARD HALL—A REALITY AT LAST

*Gregory F. Handlir*

In June 1969, the Board of Regents of the University of Maryland passed a resolution approving in principle the expansion of the incoming medical school classes to 200 students at such time as land and facilities would become available to support adequately classes of this size. In June 1973, this resolution materialized in the form of concrete and steel as construction of the addition to John Eager Howard Hall finally got underway.

A brief review of the expansion of the medical school student body over the past fourteen years in comparison with the expansion of facilities highlights the critical need for additional space. In 1961 the School of Medicine admitted 100 students. In 1962 the freshman class was increased to 128 students and in 1967 to 136. At present the first-year class stands at 155 students, a 55 per cent increase above the 1961 level. During this same period of time the school for its teaching and instructional-related health research programs remained constant. In fact, three of the buildings: Davidge Hall, Gray Laboratory, and the Medical Technology Building were constructed prior to 1964. The Howard Hall Addition, scheduled for completion in 1975, represents a significant step in the School of Medicine's plan to expand its entering class to 200 students. Specifically, the fourteen-story structure will provide an additional 176,347 net square feet of teaching and essential research space. It will house lecture halls and classrooms, teaching laboratories, basic science and clinical department laboratory and faculty areas, and the administrative offices of the Dean of the School of Medicine. The building will be linked physically to the two other major facilities of the school—John Eager Howard Hall and University Hospital—and is envisioned as becoming the hub of activity for the school.

In planning the addition of space for the School of Medicine three criteria were used; first, the provision of a sufficient amount of additional space to bring the school to at least the necessary minimum for its student and faculty complement. Second, the provision of modern instructional facilities and adequate student oriented areas which at present are lacking. Third, a consolidation of departmental space which in many cases is presently fragmented into more than one building.



To determine the total space required for the projected student and faculty body two types of analyses were performed. These analyses involved a department by department study of space needs and a study of space available to other schools of medicine with comparable programs.

At present essentially all of the school's instructional space is located in the existing John Eager Howard Hall, the exception being the gross anatomy labs located in the Bressler Research Building. The John Eager Howard Hall was acquired by the University in the late 1950's and was formerly a department store and warehouse. The structure of the building would not allow sufficient open space (without obstruction) or ample floor to ceiling height to construct adequate lec-

ture facilities. The two existing lecture halls seat 160 students but approximately 20 per cent of the seats provide less than adequate view of the black boards and projection screens. These will be supplemented by two modern lecture halls located on the first floor of the new building. Additionally, study areas, a student common room, student offices and a student mail room will be located on the first floor. There will also be small classrooms on nine floors of the building for small group meetings. The lack of small classrooms is at present a serious problem, particularly for the basic science departments. The second floor of the building will house a new gross anatomy laboratory to replace the current undersized and outdated one located in the Bressler Research Building.

The decision to construct an addition to the present John Eager Howard Hall was predicated largely on the basis of being able to consolidate departmental space, particularly in the basic science departments. In effect the first six floors of the new building will be extensions of the existing building. For example, the Department of Microbiology which is located on the third floor of the existing structure will expand onto the third floor of the new building. This allows the department to expand into contiguous space while eliminating the need to move the entire department.

This same concept was applied to other basic science departments which occupy space in the existing building. Each of the six floors of the present structure are interconnected to the new building by one or more passageways. The new building will also be connected to the University Hospital by means of a bridge at the second floor level. This bridge is considered to be a very important feature in the school's planning as it allows easy access from one building to another and should promote more interaction between clinical and basic science faculty. The bridge will also be used to transport patients to Howard Hall for teaching purposes.

The new building is designed around twenty feet by twenty feet modules with a center core for utilities. This design will allow for relatively easy modification of laboratory sizes if required at a later date. All utilities are readily available in the core and can be extended to virtually any location in the building. The total space made available by this structure is 333,700 gross square feet or approximately 176,347 net assignable square feet. The building will be served by four passenger and one freight elevator. Delivery of supplies and equipment will be accomplished by means of an

existing underground loading area located in the present building.

The expansion and replacement space provided by this addition to John Eager Howard Hall is essential to the school to meet its current educational commitments. As previously indicated, the school has expanded beyond its present physical facilities. The new classrooms will be utilized almost exclusively for the teaching of electives within the framework of the new curriculum. The frequency with which they are used and the number of students in each course (density) will depend on the number and kinds of courses offered. Additional electives and a greater variety of pathways in and out of the new curriculum will require the extensive utilization of small conference and seminar rooms as well as the conversion of some existing space.

After completion of the addition to John Eager Howard Hall, the medical school entering class will likely be increased to 170 students. It is anticipated that the School of Medicine will realize its goal of 200 entering students during fiscal 1976 following completion of a second Medical School Teaching Facility that has been funded and for which beginning construction is anticipated in the near future.

In summary, the Howard Hall Addition represents a most significant stride in bridging the gap between class size and facilities which has been a constant source of frustration for the School of Medicine. The importance of the addition can best be understood if one examines the total responsibility of the academic medical center. No other form of health education carries the magnitude of responsibility for education, service, and research. The School of Medicine is responsible not only for undergraduate medical students but also for graduate students in the biological sciences, postdoctoral students in both clinical and preclinical science, allied health personnel and the continuing education of a large number of health professionals.

*Ed. Note: The author is Assistant Dean of the University of Maryland School of Medicine.*

# Office of Medical Education U. of M. Medical School



Murray M. Kappelman, M.D.

The formation of the Office of Medical Education, University of Maryland Medical School was based upon the administration's belief that a unit which has knowledge and interest in all aspects of medical education would be valuable to faculty and students as a consultant agency, working toward the upgrading and continued progress of the University of Maryland Medical School's educational process. This has been the guiding principle under which the Office has been operating.

The Director of the Office is a faculty member, Dr. Murray Kappelman, Associate Professor of Pediatrics, who has been in charge of the Pediatric Clerkship program for the past fourteen years. The Associate Director within the field of education has skills in the areas of instructional design, techniques and evaluation. The Director of Media brings to the office expertise in media and all aspects of media production. Other personnel include a Study Skills expert, a Media Specialist, Librarian, an Audiovisual Technician, two Graphic artists, and a secretarial staff.

During the past year, the Office has installed slide-tape study carrels and video study carrels in each of the Freshman and Sophomore multidisciplinary labs, as well as in the Cardiology learning area. At least one slide-tape study carrel and one video tape study carrel have been installed in each of the clinical departments within the hospital. An early evening software Medical Education Library has been established in the Office of Medical Education within Howard Hall for the use of the medical students during the week.

Software has been purchased from external sources and is available in the Office now for sign-out study, and an updated software catalog is available in each Department and in the Office which lists all available software media. Members of the University of Maryland Medical School faculty have created software for utilization, some of which are available and some of which are in the process of production. Video tapes have been developed by Dr. Roy Guyther of Family Practice and Dr. Ross Schneider of Neurosurgery. Slide-tape programs have been developed or are in the process of being developed by Dr. Gladys Wadsworth, Anatomy; Dr. Ross Kessel and Dr. William Meyers, Microbiology; Dr. Leo Karpeles, Physiology; Dr. Richard Morton, Social and Preventive Medicine; Dr. Gerard Hunt, Psychiatry; Dr. Martha Majasko, Anesthesiology; Dr. Wolfgang Mergner, Pathol-

ogy; and Dr. Thomas Hobbins, Medicine. During the past year, the Department of Anatomy in cooperation with the Office of Medical Education developed handouts including illustrations for some of the films shown during the Freshman Anatomy course.

A computer terminal has been installed in the Cardiology learning area, the Department of Surgery, as well as the Office of Medical Education. These computer terminals tie in with the Massachusetts General-Lister Hill Network as well as Ohio State and Illinois Medical School.

The Office of Medical Education is currently responsible for two different types of tutoring programs and one program is designed to improve study skills. The Graduate, Senior, Junior student tutoring program and the peer tutoring program are currently operant as is the Hanau study skills improvement program, the latter under the guidance of Miss Sandra Chappell, a member of the Office of Medical Education. During the summer of 1973, both classrooms 256 and 258 of Howard Hall were upgraded regarding media and general teaching facilities. Plans for the upgrading of 1-704 Psychiatric Institute and Gordon Wilson Hall have been submitted to the administrative authorities for approval and implementation.

The Office of Medical Education tapes all of the Freshman and Sophomore lectures. During a recent week in the fall, 125 tapes of Freshman and 35 tapes of Sophomore lectures were signed-out from the media library for utilization that specific week. The addition of slides, which are automatically timed to the auditory part of the lecture has been accomplished by the Office in some cases.

During the summer of 1973, a summer program was held during which five members of the Basic Science faculty, a member of the Clinical Science faculty, three medical students and the staff of the Office of Medical Education participated in a 7-week course devoted to some of the important aspects of medical education. This program resulted in the initiation of a great deal of activity by our faculty in the development of objectives, initiation of media and other software and meaningful exchange between faculty and students relative to the process of medical education within the University of Maryland Medical School. Funding has been made available for continuation of this "summer program" during the summer of 1974.

A portable, take-home individualized study system has been developed for the first and second year medical students including the ability to sign-out slide-tape programs, audio-tape programs, and microfiche programs.

Students are participating in the Office of Medical Education as student projectionists and student librarians. Consultation with class members of all classes has been extremely valuable in program planning by the Office. In addition, the Office has benefited greatly from the ongoing constructive advice and suggestions of the faculty.

*Ed. Note: Dr. Kappelman is Director of the Office of Medical Education, University of Maryland School of Medicine.*

# The Baltimore Cancer Research Center: New Faces And Friends For The University Hospital

Nicholas R. Bachur, M.D., Ph.D.

For more than a year, discussions hummed between the National Cancer Institute and the University of Maryland concerning an alliance of the Baltimore Cancer Research Center (BCRC) with the University of Maryland Hospital. Now, this union between the Federal and State Governments, dedicated to the improved care and research of cancer patients, is official; and the move of the BCRC to the University of Maryland has begun.

The BCRC was conceived in 1966 when need for clinical research facilities pressed the National Cancer Institute to look outside of the Bethesda campus for other clinical space. Since the U.S. Public Health Service Hospital at Wyman Park had available space, the BCRC, consisting of a clinical service and research laboratory, developed. During its short adolescence, the BCRC has grown in personnel and size, and has attained international recognition for the modern therapy of oncologic diseases.

Today the Division of Cancer Treatment of the National Cancer Institute continues to conduct a multidisciplinary program in cancer research and therapy at the BCRC under the stewardship of Dr. Michael D. Walker. Clinical programs are concerned primarily with the treatment of cancer by drug and combination therapy programs. The clinical programs are integrated with the laboratory in the fields of pharmacology, biochemistry, immunology, and microbiology. This approach provides comprehensive care of patients with malignancy according to carefully designed therapeutic protocols.

The Clinical Branch receives referrals from the community and maintains 40 to 50 active beds of adult and pediatric patients. Presently, the total therapy program is involved with treatment of leukemia, lymphoma, primary metastatic brain tumors, sarcoma, testicular tumors, and other solid tumors. Included in the Clinical Branch are Medical Oncology, Neurological Surgery, and Radiation Therapy Service. The major emphasis has been placed upon Phase I, II, and III studies which are designed, conducted, and evaluated in conjunction with toxicologic and pharmacologic investigations carried on with the Laboratory of

Pharmacology. New investigational drugs and conventional chemotherapeutic agents are studied both singly and in combination with radiotherapy and surgery. These studies are designed not only to provide patients with optimal care, but also to investigate therapeutic potential of these new and innovative approaches.

In the Section of Medical Oncology under the direction of Dr. Peter H. Wiernik, studies for the prevention and therapy of infections in the cancer patient and evaluation of protected environments are carried out. Studies on immunological competence in malignancy, bone marrow and tumor cell kinetics, and research for early biochemical markers of occult neoplastic disease are active. Research and on-line efforts in patient support programs such as platelet and white cell transfusions and intensive care facilities are part of the Medical Oncology program. A combined effort is made to develop computer techniques for patient information storage and retrieval.

In the Neurosurgical Section headed by Dr. Michael D. Walker emphasis is placed on patients with both primary and secondary malignant brain tumors. Therapeutic potentiation of operative intervention is obtained by the use of the nitrosourea compounds as well as irradiation. The pharmacologic distribution and disposition of drugs are studied with special emphasis upon the evaluation of blood-brain barrier dynamics, so as to provide optimal therapeutic concentrations of drug at the site of the tumor. A program toward the better understanding of the treatment of meningeal leukemia is in progress.

Pharmacist Clarence Fortner supervises a specialized Patient Care Pharmacy which provides quality control by the pharmacist making rounds with the physicians, preparing unit doses and intravenous adjuvant service. Coordination of the various patient care activities is provided by a series of computer programs utilizing the problem-oriented data coordination system, census program, treatment printout, and microbiologic reporting system.

Dr. Viola M. Young heads the Microbiology Section in clinically oriented studies of microbial flora in cancer patients. These studies utilize com-

sterized reporting of laboratory microbiology results. Other efforts are being made to improve microbiology laboratory techniques.

In conjunction with its inpatient population, the BCRC operates an Outpatient Department and Special Ambulatory Care Program. Patients are seen in the OPD for initial evaluation, follow-up, continued treatment. Those needing hospitalization are admitted directly and others may be followed on a frequent basis in the OPD. In addition, patients who live a distance from the hospital and normally would be seen as outpatients, or those who are well enough to live outside the hospital may be placed on our Special Ambulatory Care Program. These patients reside in a nearby hotel, taking meals at the hospital or motel; and return to the hospital like an outpatient. This category is best for patients who are receiving daily therapy (radiation or chemotherapy) for several weeks and therefore need to be in the vicinity of the hospital but do not need to occupy a hospital bed. The relationship of inpatient, outpatient, and Special Ambulatory Care Program patient is fluid depending on the patient's need and the degree of supervision required.

During the past year the BCRC provided approximately 5000 Special Ambulatory Care Program patient days. In addition, there have been about 5000 outpatient visits for evaluation, treatment, and follow-up. It is anticipated that with the developing programs there will be an increase in the utilization of both these areas as a result of the efficiency of this method of patient care.

As part of the Laboratory of Pharmacology, the Biochemistry Section headed by Dr. Nicholas R. Bachur integrates closely with the clinical programs of the BCRC and carries out a program in clinical pharmacology. Methods for drug assay, and the pharmacodynamics and pharmacokinetics of chemotherapeutic agents are studied. Central to this have been studies on the biotransformation, the mechanism of action, and the structure-activity relationships of drugs. Other general areas of investigation include cellular and physiological control mechanisms for growth and differentiation, membrane structure and function, and enzyme structure and function.

Dr. Michael R. Mardiney Jr. heads the Immunology and Cell Biology Section in a multidisciplinary approach to tumor immunology. Most recently these studies have centered on the mechanism of human lymphocyte reactivity to non-self, the immunologic effects of BCG and its relationship to cancer chemotherapy, the identification of tumor specific antibody and the detection

of antigen-antibody complexes in renal glomeruli.

The Section of Enzymology and Drug Metabolism under Dr. Carl C. Levy is emphasizing the development of specific nucleases, RNAases and DNAases, to aid in sequencing studies of nucleic acids. Additional studies on the metabolism of human platelets, the effects of polyamines on enzyme action, and the mechanisms of nuclease activity are in progress.

Research programs are also carried out in collaboration with research pathology on the ultrastructure of malignant cells and a myelomonocytic leukemia in an animal model system.

This very broad and integrated research front of the BCRC serves also to stimulate new clinical approaches in our common cause, the control and eventual eradication of cancer. Hopefully with the cooperation and melding of resources of the BCRC and the University of Maryland, this goal will be realized. Through collaborative teaching between BCRC staff and University of Maryland medical students and house staff, the BCRC may add new dimensions to the medical and paramedical training at University of Maryland, and will accelerate the dissemination of new cancer treatment techniques and new clinical and research findings to the medical community.

*Ed. Note: Nicholas R. Bachur, Ph.D., M.D., 1961, University of Maryland, is the Head of the Section of Biochemistry and the Head of the Laboratory of Pharmacology of the Baltimore Cancer Research Center. Dr. Bachur was born in Baltimore, did his undergraduate education at Baltimore City College and the Johns Hopkins University. Following his graduation from the School of Medicine, he did a straight medical internship at the University of Maryland Hospital and then began his investigative career at the Laboratory of Clinical Biochemistry, National Heart Institute, Bethesda, Maryland. Dr. Bachur is a recipient of several national awards, and served on the editorial board of Biochemical Medicine. He belongs to numerous national and international organizations, and looks forward to his return to the University of Maryland campus.*

# Baltimore Campus Allied Health Schools

## THE CHANGING FACES OF DENTAL EDUCATION

### The Anatomy of The Clinical Dental Curriculum at The University of Maryland

*John F. Hasler, D.D.S., M.S.D.*

*John J. Salley, D.D.S., Ph.D.*

The demand for health care services has increased steadily during the past two decades.<sup>1</sup> In part, this demand results from society's philosophy that "health care is a right, not a privilege". The impact of this philosophy on the health science professions is being felt in the increased demand for more physicians, dentists, and ancillary personnel.

It is apparent from the content of many publications and scientific meetings of the past ten years, that intense curricular revisions and modifications are occurring at many dental schools.<sup>2</sup> Education must be considered as an orderly process which changes the learner. This implies that the interactions between students and faculty must be designed to attain certain goals which would not have occurred without the educational process. Society, i.e. patients, professional organizations, students, faculty, and the media, influence decisions regarding the goals that are desirable and the goals that should be pursued. Achievement of these goals depends upon the selection of optimal teaching methods on the basis of hypotheses derived from learning and instructional theories. The correctness of instructional decisions must be assessed by evaluation.

The present revolution in medical and dental education is often traced to the extensive curricular changes initiated at Western Reserve University in the early 1950's.<sup>3</sup> At that institution, the traditional lockstep, departmentally-oriented curriculum was replaced by a more flexible educational program stressing interdisciplinary approaches for both the biomedical and clinical sciences. This movement has continued to spread very slowly for the past twenty years.

At present there are 57 dental schools in the United States.<sup>4</sup> Five of these are new schools which accepted their first class in 1972. Many of



*Team Teaching instruction is provided for comprehensive patient care in the clinics of the University of Maryland School of Dentistry.*

them have unique programs. The trend today is to reduce the number of required student contact hours, to provide more free time in the curriculum for student self-study or the pursuit of electives, and to shorten the length of the curriculum. Bohannan et al<sup>5</sup> have suggested that dental educators must disavow any educational program that is based primarily on time in residence and must admit that no student can learn everything a dentist must know within any period allocated for dental education.

Not all dental schools have made an effort to implement innovative curricula, but Allen<sup>4</sup> points out six basic areas of emphasis for this change:

1. The outstanding student may be admitted to dental school earlier than before;
2. The dental curriculum will become more people-oriented and less technique-oriented;
3. Teaching methodology will become more self-instructional;
4. Behavioral objectives will commit the learning to a self-paced basis;

5. Students will learn more about dentistry earlier in their dental education, permitting greater elective flexibility and earlier specialization;
6. Students in dental school will have the opportunity to advance at their own individual rates.

## **The Clinical Dental Curriculum at The University of Maryland**

Since the principal objective in undergraduate dental education is the preparation of the student for general practice<sup>6</sup>, the clinical experience should allow the student opportunities not only to make use of previous learning, but also to develop further skills in rendering patient care. Toward this end, the University of Maryland School of Dentistry has initiated major curricular changes during the past eight years. The following new and often innovative programs represent several of the new curriculum modifications in the changing areas of dental education:

1. **COMPREHENSIVE CARE . . .** Comprehensive or coordinated clinical patient care demands that the student will perform, where his ability permits, all dental services for the individual patient, from the preliminary workup to the completion of treatment, with emphasis on the proper chronological approach to patient management. This involves examination, diagnosis, treatment planning, case presentation, appointment control, prevention orientation, treatment performance, and patient recall.

Each student is required to introduce and maintain a sound prevention philosophy during all phases of his dental treatment. Emphasis is placed upon the student's concern for the total oral health of the patient as it relates to the total systemic health. Not only is technical management of a variety of cases provided through comprehensive coordinated treatment, but clinical experience is also provided in dentist-patient relations.

2. **COMMUNITY SERVICE . . .** Annually, over 92,000 patient visits are recorded at the School of Dentistry, including almost 5,000 annual visits for the relief of pain and other dental emergencies. As the largest single provider of community dental care in the State of Maryland, the community service contribution is reflected in the provision of a

facility for the delivery of services to those admitted. Maintaining an open admission policy for all who apply, once a patient is accepted for comprehensive treatment, he should be:

- a. promptly appointed by the student for definite appointments;
- b. oriented in prevention;
- c. provided the best treatment plan, according to *his* needs;
- d. provided systematic progress toward case completion;
- e. provided continuing maintenance, preventive measures, and follow-up care.

No longer should a patient be accepted for individual services or manikin treatment, but patient education must be provided to permit acceptance of care on a total health basis.

3. **COMPUTERIZED DATA RETRIEVAL . . .** Data bases are maintained at the School of Dentistry for not only the patient's, but the student's profile as well. All new patients are first registered, where the biographical information, including the past medical and dental histories, is computerized for information retrieval. Each student initiates his clinical care experience early in the second year. As each new patient is assigned to him, a record of the projected dental care is recorded on the student's individual computer printout. As treatment procedures are completed, a comprehensive profile is developed for the remaining clinical years of each student's educational experience. Integrated with this data base are the grade program and special assignments printouts.

4. **SPECIAL PROGRAMS . . .** In the development of the clinical curriculum at Maryland, the following special programs permit the student to expand his basic knowledge of dental practice:
  - a. *Conjoint Science . . .* An integrated, inter-departmental, four-year program coordinating basic, applied and clinical sciences.
  - b. *Biomedicine . . .* Coordinated integration of Oral Pathology, General Pathology, Internal Medicine, Physical Diagnosis, Oral Diagnosis, and Dental Radiology into one overall educational experience.
  - c. *Independent Learning Center . . .* A continuously operating self-instructional learning center where independent stu-

dent activity permits the introduction of new modular learning units and the self-paced reinforcement of previously presented material.

- d. *TEAM Program* . . . Through a pilot training program, advanced clinical students obtain experience in practice mechanics through participation in the expanded duty patient clinic.
- e. *Accelerated Professional Training* . . . Previously selected students may participate in a pilot program directed toward accelerated professional training in less than the conventional four-year program.
- f. *Special Patient Clinic* . . . Assignment to this clinic presents an opportunity for the advanced clinical student to obtain experience in the management and treatment of the special or handicapped patient. One of the few such facilities at any dental school in the United States, patients who present with chronic medical disorders which resist traditional dental therapy, may receive elective dental care on a regular basis.
- g. *Senior Clerkship Program* . . . On an elective basis, qualified Seniors may devote up to fifty percent of their last school year in a dental discipline of their choice.
- h. *Dental Externship Program* . . . This program, awaiting approval by the Maryland Legislature, will allow selected fourth year students to devote eight weeks of field study on location in the office of a practicing field instructor dentist in the State of Maryland. Not only will the Extern provide dental care in that community, but he will obtain valuable experience in practice dynamics at the private sector level.
- i. *Community Dentistry Enrichment* . . . All students participate at one of several levels in the four-year development of an understanding of the dental care delivery system at the community level.

Additional programs in Continuing Education, Post-Graduate Education, and Dental Hygiene provide the student, the patient, and the community with broader educational experiences. An Oral Medicine Consultation service provides dental practitioners and patients in Maryland with a University-based referral center for case evaluation and consultation.

## SUMMARY

Dental education is responding to the challenges of patient care through new and often innovative curriculum changes. Several of the programs at the University of Maryland, which are the results of this challenge, have been presented. The humanistic approach to patient care is being emphasized while allowing the student maximum flexibility for educational enrichment. Future trends and demands will place further burdens on dental educators to develop educational programs which permit this flexibility. Dental licensing bodies must recognize these changes in educational philosophy, and must encourage all practitioners to continue to enrich their educational experience on a regular and voluntary basis. The University of Maryland School of Dentistry looks forward to the future and the continued improvement in the delivery of dental health care.

*Ed. Note: Dr. Hasler is Assistant Dean for Clinical Affairs, and Chairman, Oral Diagnosis/Dental Radiology, School of Dentistry, University of Maryland at Baltimore.*

*Dr. Salley is Dean of the School of Dentistry, University of Maryland at Baltimore.*

1. Horton, P. S., Soule, D. J., and Cavanaugh, C. T.: *Procurement of Teaching Patients: Cooperative Effort Between Social Service Agencies and Dental School.* *J. Dent. Educ.*, 37: 41, Nov. 1973.
2. King, A. D., Allen, D. L., Mackenzie, R. S., and Medina, J. E.: *A Modular Curriculum Design for Dentistry.* *J. Dent. Educ.*, 37:20, June 1972.
3. Cooper, J. A. D.: *Curriculum Reforms in Medical Education.* *J. Dent. Educ.*, 37:13, Jan. 1973.
4. Allen, D. L.: *Current Trends and Projections in Dental Education.* *J. Dent. Educ.*, 37:32, May 1973.
5. Bohannan, H. M., Rovin, S., Packer, M. W., and Costich, E. R.: *The Flexible Dental Curriculum.* *J. Am. Dent. Assoc.*, 84:112, 1972.
6. Williams, A. K.: *System of Clinical Counseling for Dental Students.* *J. Dent. Educ.*, 37:15, Dec. 1973.

# THE GRADUATE SCHOOL

## The University of Maryland at Baltimore

John P. Lambooy, Ph.D.

The Graduate School of the University of Maryland was established in 1918 under the jurisdiction



John P. Lambooy, Ph.D.

of a Graduate Council with the Dean of the Graduate School serving as chairman. It was created for the purpose of developing and administering programs of advanced study and research for graduate students in all branches of the University. In

1970, as part of the reorganization of the central administration of the University, the Graduate School component on each campus became operationally autonomous with its own Graduate Council and a Dean for Graduate Studies and Research serving as chairman.

The total University's involvement in graduate education finds expression in the President's Advisory Committee for Graduate Studies and Research. The membership of this committee is made up of ex officio members and appointed members drawn from all the components of the University. The Vice President for Graduate Studies and Research is chairman of the Advisory Committee.

Despite the large expansion of graduate programs into new areas as the University has grown, the philosophy of each program is essentially that of individuals studying under competent supervision. The Graduate School is not made up of extensions of undergraduate programs or professional training programs, but was created for the preparation of those individual students who, in the future, will carry on the spirit and practice of scholarly inquiry. Thus, it promotes and provides an atmosphere of research and scholarship for not only the students but for the faculty as well; it stimulates the harmonious relationship between students and faculty which results in the advancement of learning. At the present time 82 graduate programs are authorized leading to one or more of the advanced degrees awarded by the University upon the recommendation of the campus Graduate Faculties. Of these eighty-two,

twenty programs are conducted by the Graduate Faculty of the University of Maryland at Baltimore and two are joint programs conducted by some of the members of the Graduate Faculties of the two campuses, the University of Maryland at Baltimore and the University of Maryland, Baltimore County.

Members of the Graduate Faculty of the Baltimore City Campus are drawn from among the faculty members of the departments of the Schools of Dentistry, Medicine and Pharmacy and the Schools of Nursing and Social Work and Community Planning. The 168 members of the Graduate Faculty are those individuals who are authorized to teach and advise graduate students enrolled in graduate programs leading to advanced degrees. Thus, for example, since the School of Law, or the Department of Medicine, or the Department of Restorative Dentistry are not authorized to conduct training programs leading to graduate degrees, they do no teaching of graduate students. Not many of the faculty members of similar areas are made members of the Graduate Faculty. On the other hand, virtually all members of the basic science departments of the Schools of Dentistry, Medicine and Pharmacy are members of the Graduate Faculty. Since the Schools of Nursing and Social Work and Community Planning conduct graduate programs, some of the members of the faculties of these Schools are also elected to membership on the Graduate Faculty.

The Graduate Council is responsible for developing and administering the graduate programs; to establish policies and procedures for the operation of the Graduate School. The Graduate Council is composed of ex officio members and two groups of elected members; one group is elected by the members of the Graduate Faculty in each of the individual participating professional Schools and the other group is elected from the Graduate Faculty at large. The ex officio members are President Wilson H. Elkins, Chancellor Albin O. Kuhn and Dean John P. Lambooy. The members representing the Graduate Programs of Schools are Dr. Donald E. Shay (Dentistry), Dr. Raymond A. Sjodin (Medicine), Dr. Lisa Robinson (Nursing), Dr. James Leslie (Pharmacy) and Dr.



Harris Chaiklin (Social Work and Community Planning). The members elected from the Graduate Faculty at large are Dr. Ross W. Kessel, Dr. Gardner Middlebrook and Dr. Frederick J. Ramsay (Medicine), Dr. John I. White (Dentistry) and Dr. Nicolas Zenker (Pharmacy).

The University of Maryland at Baltimore awards only five graduate degrees, they are Master of Social Work, Master of Community Planning in Social Work, Master of Science, Doctor of Social Welfare and Doctor of Philosophy. The Doctor of Philosophy degree can be earned in the disciplines of anatomy, biochemistry, biophysics, cell biology, medicinal chemistry, microbiology, pathology, pharmacognosy, pharmacology, pharmacy and physiology. Master of Science degrees can be earned in each of the above disciplines as well as in nursing and oral surgery.

Starting in September 1973 two programs conducted jointly by the Baltimore County Campus and the Baltimore City Campus were authorized. Those programs provide training leading to the Doctor of Philosophy and the Master of Science degrees in Experimental Biology and Health Sciences and leading to the Master of Science degree in Biological and Medicinal Chemistry. The initial principle emphases of these programs will be at the Baltimore County Campus but as more generalized programs of training gain popularity, increasing interest will quite naturally develop on the Baltimore City Campus.

At present there are more than 900 students enrolled in graduate programs on our campus. Approximately half of these are enrolled in the Master's programs in the School of Social Work and Community Planning. An impression of the varied nature of the training available to those students in the many disciplines described above can be gained from the knowledge that 388 courses are made available to graduate students on our campus.

To this point the structure and organization of the Graduate School has been described. Since this informational article is to appear in the Bulletin, School of Medicine, it seems appropriate that some time now be spent describing the graduate programs conducted in the basic science departments of the School of Medicine.

Forty-two percent of the Graduate Faculty are members of the faculty of the School of Medicine most are in the basic science departments. Of the total number of graduate students on the campus working toward the Doctor of Philosophy degree 70 percent are enrolled in the programs conducted by the basic science departments of the School of Medicine. Only one of the programs makes a practice of admitting students for the purpose of studying for the Master of Science degree. The exception will be discussed briefly later. Keeping in mind that most of the graduate students enrolled in programs in the School of Medicine are working toward the Doctor of Philosophy Degree, a brief description of the programs is in order.

The Department of Anatomy is currently chaired by Acting Chairman, Dr. Frederick Ramsay. It is possible for students to specialize in one of the areas such as neuro-anatomy, gross anatomy, microanatomy or electron microscopy. While all candidates are required to show competence in these areas, their dissertation research is usually in one of these areas of specialization.

Dr. Elijah Adams is Chairman of the Department of Biological Chemistry. The graduate program embraces several of the traditional areas of biochemistry but the department specializes in all aspects of enzymology. The metabolism of proteins and amino acids, of hemoglobin as well as biochemical regulation and microbial biochemistry are also strengths of the department.

The Chairman of the Department of Biophysics is Dr. Lorin Mullins. The department attracts students interested in developing competence in research on biological and model membrane systems. Thus, the current research interests center on the physical and chemical basis for transport across cell membranes, genesis and control of



Frederick J. Ramsay, Ph.D.



Elijah Adams, M.D.



Lorin J. Mullins, Ph.D.

membrane potentials, excitation, and the X-ray diffraction study of single crystals of biological molecules.

Dr. Edson Albuquerque has recently been appointed Chairman of the Department of Cell Biology and Pharmacology. Dr. Albuquerque has not yet arrived to assume his new duties but when he arrives there is little doubt that the graduate program in the department will be activated once again. The department's current research interests are in the areas of nucleic acids and proteins.

The Department of Microbiology is Chaired by



Charles L. Wisseman, Jr.,  
M.D.

Dr. Charles Wisseman. Research programs leading to the doctoral degree are available in the areas of virology, rickettsiology, medical bacteriology and immunology. Opportunities exist for ecological studies on rickettsioses and arboviruses in overseas areas.

Dr. Benjamin Trump is Chairman of the Department of Pathology. Much of the interest of the



Benjamin F. Trump, M.D.

department centers around the ultracellular structure of tissues and how the physical aspects and metabolism of these are altered by stresses and disease processes. Because of the unique history and organization of the graduate program in

the department, not only is it possible to study for the Doctor of Philosophy degree in Pathology, but also in Legal Medicine. The Director of the latter program is Dr. Russell Fisher who is also the Chief Medical Examiner for the State of Maryland. Research in Legal Medicine deals with a study of the effects of poisons on the living cell and methods for the detection, identification and assay of these materials. The Department of Pathology is the de-

partment which actively seeks students interested in working for the Master of Science degree. By far the majority of these are interested in the specialized course of study with concentration in Clinical Pathology or in more contemporary terms, Medical Technology. Dr. Jason Masters is Director of this area of specialization.



Jason M. Masters, Ph.D.

The Chairman of the Department of Physiology is Dr. William Blake. Students are able to do their dissertation research in the areas of electrobiology, endocrinology, gerontology, membrane, cardiovascular, renal, and neurophysiology.



William D. Blake, M.D.

During the decade of the 60's, graduate education enjoyed a rapid growth throughout the United States. While several factors contributed to this growth, perhaps the single most important element was the availability of money from the federal government in the support of science and research. To insure a growing supply of scientists to meet the demand for the well supported and growing scientific community, the federal government decided to support the training of scientists as well as scientific research.

Many basic science departments in schools of medicine, throughout the United States, were given Training Grants by the National Institutes of Health. Such grants provided money for stipends for students as well as money to support some of the research training for the students. Several departments in the School of Medicine had such Training Grants. About 1970, for a variety of reasons, ranging from almost totally correct to almost totally incorrect, the concept of Training Grants was abandoned by the NIH; within a very short time this source of funds simply disappeared. Since graduate students in basic science departments in medical schools had rarely paid their own way because they were concurrently employed as paid teaching assistants, the availability of Training Grants caused many departments which ordinarily would have in residence not more than two or three students to increase their enrollment from 5 to often more than 10 times the former number. Such growth greatly increased

the research productivity of departments as well as enriched the "life style" of these departments. The growth just described took place over nearly a decade; the reverse process, that is the phasing out of such support, has taken approximately three years.

To cite an example of the change brought about by the discontinuance of Training Grant support we can look at our Department of Biological Chemistry. During the seven years 1962-1969, 16 students were trained for the Ph.D. During the 4 years 1969-1973, only 4 students were graduated. The "department" is today better qualified and better equipped to train graduate students than it has been at any time before, yet, as a result of almost total lack of support for graduate students it is increasingly difficult to continue a graduate program.

It is extremely difficult to predict what will happen during the next 5 years. There are reports that

more money will again become available for graduate students but in what form and in what areas will not be really known until official awards are made. Perhaps emphasis will be placed on loans rather than stipends for students. There is a possibility that more money will become available to provide postdoctoral training for recent Ph.D. recipients. Times are very uncertain and we all speak hopefully of a return of better times. Since wishing will not make it so, it will take a reawakening of the realization that graduate education, especially in the sciences, is a valuable national resource.

The author takes this opportunity to express his appreciation to Mr. Philip Szczepanski for his excellent, and patient, photographic work in support of this article.

*Ed. Note: Dr. Lambooy is Dean for Graduate Studies & Research, University of Maryland at Baltimore.*

## THE NEWEST SCHOOL ON CAMPUS: A PARTNER IN MEETING HUMAN NEEDS

*Daniel Thursz, D.S.W.*

Early in January of this year, a telegram arrived on campus signifying the end of a two-year process which culminated in a four-day visit by a team of distinguished educators. The telegram announced that the School of Social Work and Community Planning of the University of Maryland at Baltimore had been given the maximum number of years allowable under the rules for reaccreditation of the Council on Social Work Education: ten years. The process of self-study had involved all members of the School's faculty which now numbers close to eighty, many of the students, representatives of a whole variety of agencies in which students are placed for internship or field instruction and a most exhaustive study of the School's first decade. No one could have predicted in 1961 when the first class of students entered a warehouse, euphemistically known as Redwood Hall, that this new fledgling on the campus would grow into the third largest school of social work in the country in just ten years, taking its place alongside the Columbia University School of Social Work and the School of Social Work at the University of Michigan.

Its significance is not only based on the size of its student body, with 500 graduate students and

an almost equal number of undergraduate students in a program conducted at the nearby campus of the University of Maryland Baltimore County (UMBC). Indeed, the School has pioneered in new formulations for social work education and has developed a broad concept of social work responsibilities which makes it a unique, avant-garde school whose lead is now being followed in a number of schools throughout the country.

In the process, it has revolutionized much of social work practice and has extended the field of activities of social workers far beyond the so-called traditional agencies. This has not come easily and there have been the normal successes and failures associated with curriculum changes and with the development of a complex and ambitious system. In particular, the School has had to suffer with the rest of the field of social work from the persistent mythology that characterizes social work either in terms of the distribution of welfare checks or as somewhat old-fashioned ladies in tennis shoes who "want to do good".

Within medical settings, too often the social worker is seen as a history taker or someone to locate an empty nursing home bed rather than a

partner in a professional team whose goal is the re-establishment of health in its fullest sense.

The problem of definition of the social work profession does not find its roots only in the general public—within the profession itself in past decades the social worker was seen essentially as a caseworker, providing one to one counseling on a regular weekly hour basis, often across a desk in the well protected surroundings of a social agency.

Much of the activities of the School has been developed to shatter these myths and to educate students according to a number of specializations or practice models on a broad continuum. Today's social worker must make a significant difference to client and to the community.

The reformulation of the School's curriculum has been based on a series of assertions: The first is that education for social work requires specializations. The extension of the field makes it impossible for any one individual to have sufficient skill, even at the beginning level, to enter the arena of social work endeavors and to meet all the needs of client systems. Although there is, and will continue to be, a generic core of foundation knowledge and values, the social worker of today must designate upon entry into our professional school of social work, a specific specialization. At the present time at the University of Maryland there are three such specializations: clinical social work, social strategy and social administration. A fourth experimental specialization is in the area of planning—a new and potentially very significant area of the School's activities.

The clinical social worker continues to represent the majority interests of our student body. Nearly 70 percent of the students at the School prepare for clinical social work practice. Unlike the old type caseworker, however, today's clinical social worker is trained to use both individual and group methodology in dealing with individuals or families in social crisis. The range of services provided by clinical social workers today range from marital counseling and family therapy to efforts to make appropriate plans with individuals and families whose lives are transformed by sudden illness, accident or major new health problems. Such services are given under the auspices of public and voluntary social agencies, hospitals, nursing homes, a variety of institutions, community mental health centers and, increasingly, private auspices. Social work services are mandated under the new legislation for health maintenance organizations and third party payments and a

number of states include services by social workers in cooperation with physicians and other health personnel.

The social strategist, on the other hand, is not engaged in therapeutic work but has been prepared instead to work with community groups, various organizations both public and voluntary in order to deal with the environment—the community problems—that affect individuals and families. Whether engaged in organizing grassroots support for self-help efforts or in the coordination of various agencies whose activities are focused on a target population, the social strategist is concerned with providing services to people who are not perceived, and who do not perceive themselves, as clients seeking the help of a therapeutic agent. This is a significant difference in the role set which distinguishes the relationship of the social strategist to citizens from the social worker engaged in clinical practice with clients.

The third specialization responds to the need today for the organization of service delivery with greater management skills, program evaluation and accountability. In this specialization, the School's goals are to prepare practitioners in managing service delivery systems. This is probably the greatest need in today's public or voluntary social agency. In a pattern not too dissimilar from that of medical institutions, the clinical practitioner has been expected to move to positions of administrative responsibility after a number of clinical practice years without the necessary qualifications for the administration of a complex system. Somehow, by osmosis, the clinical practitioner was expected to obtain the requisite skills and knowledge for coping with program development, a variety of fiscal and managerial responsibilities, negotiations with city, federal and state programs, grantsmanship, the training of paraprofessionals and evaluative research, to mention just few of the important elements of today's challenge to social administrators. By June of this year, a group of approximately fifty graduate students will have obtained their Master's of Social Work from the University of Maryland with a specialization in social administration. Most will be in positions of responsibility in public agencies such as the Department of Employment and Social Services, the Department of Juvenile Services, the Social Security Administration and a number of important federally-sponsored programs dealing with the aging, the delinquent and the aged.

The School is now giving careful consideration to a third year program available to persons who

have obtained the two-year Master of Social Work and are interested in administrative posts. A considerable amount of interest has been expressed by some of the large systems in the state of Maryland for such a program.

Although the planning concentration at the School, under the direction of Mr. Richard Steiner, formerly Executive Director of the Baltimore Urban Renewal and Housing Agency, is still very new, it has already attracted some national attention and a cadre of very able students. This program is at the very edge of the broad continuum for social work practice. Social planning has a legitimate part in the history of the development of the social work profession. Some of the earlier planning efforts in the United States were conducted by the settlement houses of our country under the leadership of persons like Jane Addams. The goal of our planning program is to synthesize concepts from the field of social planning with those from the field of physical planning. However, planning is not seen simply in terms of urban planning, redevelopment of inner city neighborhoods or the building of new towns. In addition to an emphasis on developing physical environments that are conducive to the quality of human life, increasing attention is being paid to planning in the field of social service delivery, health services, education and even transportation.

It is perhaps in the area of health planning that some of the more intriguing experiments in interdisciplinary work can be envisaged for the next few years. Such joint efforts should include the other health schools on our downtown campus as well as the Law School.

Finally, it is important to note that the School's doctoral program which began just two and a half years ago now has an enrollment of twenty-two students. This highly individualized program of study is designed to provide leadership for the field of social welfare in the state of Maryland as well as to meet some of the urgent need for teachers of social work and social welfare at both the graduate and undergraduate level. The resources of various departments at College Park and UMBC are used to buttress the program of studies in the doctoral program under the direction of Dr. Joseph Crymes.

This, then, is a bird's eye view of a large and complex system of education to meet the social challenges of the 1970's and 1980's. Although facilities for the School are scattered in three buildings on the downtown campus, it is hoped that a permanent new structure will be erected in

the next three or four years to consolidate the faculty and student body and to provide the sort of educational climate and resources that will enhance the effectiveness of our curriculum.

Each school of social work in the country has almost unique character of its own. This is due to its own history, the setting in which it is located and the philosophical stance of its faculty and administrative leadership. The School of Social Work and Community Planning at the University of Maryland is no exception. Established in a large grant state University, having developed during perhaps the most turbulent decade in American history, nestled in a setting in which are located five other professional schools at the vortex of a large and dynamic metropolitan area—the School has indeed a flavor of its own. Its philosophic commitment is to the primacy of a public social service system and to the proposition that social services are needed by all classes of people in modern society and therefore ought to be available to all, without distinction as to economic class, race or religious or ethnic origin. There is consensus on the faculty that the responsibility for the provision of social services is that of government primarily, without excluding the important contributions of the voluntary sector. It also holds that services designed for *only* the poor will ultimately become poor services.

The restructure of our social services delivery system as well as our health delivery system must be placed in a context of universal service rather than a segmented and fragmented community with hierarchical differentiation.

The stance of the School is one that invites interdisciplinary and interprofessional education as well as practice. Man must be seen as a whole person not isolated from his environment but always a part of his environment. The two, in our view, are inseparable and programs of intervention whether in medicine, social work, nursing, or other professional fields must be based on this fundamental view.

*Ed. Note: Dr. Thursz is Dean of the School of Social Work and Community Planning, University of Maryland at Baltimore.*

# CHANGES IN PHARMACY AT THE UNIVERSITY OF MARYLAND 1968-1974



William J. Kinnard, Jr., Ph.D.

Pharmacy to some people means cluttered windows, plywood shutters, heavily merchandized stores and inaccessible pharmacists. I'm often asked, "Whatever happened to the friendly corner community pharmacy?" The pharmacist was a mediator of community problems, a treater of minor ailments, and a producer of very elegant concoctions, not only in the prescription room but often at the soda fountain. Many things contributed to the changes in the profession, pharmaceutical manufacturing advancements being a prime altering factor. Today's pharmacist compounds less than three percent of his prescriptions, and in our schools we teach very little concerning that classical art of pharmacy, a regrettable but practical change in programs. The lack of sufficient prescription volume to maintain the operation of pharmacies also forced pharmacists to turn to alternate means of store support, leading to a negative feedback system of adding more and more lines of merchandise because people expected and wanted them. The pharmacy schools contributed to the problem because curricula were oriented toward the drug product. Students were highly knowledgeable about the pharmacy and chemistry of the various drugs found in the pharmaceutical products. However, the curricula did not relate to the changes occurring in health care, and because of this, effective interaction was often not seen between either the pharmacist and the physician, nor the pharmacist and the patient.

Fortunately, many within the profession recognized that a change in academic programs had to take place.

The recognition for change came at an opportune time for the University of Maryland. In 1968, the University administration decided to strengthen the School of Pharmacy to make it a strong member of the professional schools on the Baltimore Campus. An expanding faculty changed the school's curriculum, eliminating "deadwood" material and adding such new courses as: pathophysiology, therapeutics, clinical toxicology, social sciences in pharmacy, etc. It also broke a tradition in pharmacy education. Students had always followed two tracks in their education, one being the academic program and the other being the apprenticeship program which was regulated by the Boards of Pharmacy. In recent years, students had to spend one year in a pharmacy before taking the Board's examination. In most states there was little or no formal structure to this program. Thusly, a student could sweep floors or sell cigars for that length of time. The new academic program of the School provides a six-month professional experience program, during which time students serve one month clerkships in many various types of pharmacy practice or related areas throughout the State and region. The clerkships involve approximately 40 community pharmacies and 15 hospital pharmacies ranging from the Eastern Shore all the way into Virginia, each of which has a pharmacist-preceptor having a faculty appointment. Students can also spend time at NIH in research labs, the FDA, at pharmaceutical manufacturers and many different agencies in which drugs or drug information is required. A required clerkship involves the clinical pharmacy services in the University of Maryland Hospital. The Maryland Board of Pharmacy took a giant step forward in recognizing the six-month school-controlled clerkship program in lieu of the traditional internship requirements previously required. Maryland became the first state in the Union to do this, with other states following this lead (Virginia and Indiana). The obsolete apprenticeship was thus eliminated.

The School also recognized that it could not operate as an isolated enclave on the campus, when a teaching hospital, providing a pharmacy service, existed right next door. With the guidance and support of Dr. George Yeager, the School became directly involved in pharmacy programs in the University of Maryland Hospital. The Director of Institutional Pharmacy Programs became jointly supported by the Hospital and the School and some other staff positions were filled in a similar

manner. The pharmacy services, in 1968, were of the traditional type. A small staff, operating in the bowels of the Hospital, would respond to a drug order sent down to them by returning a bottle of medication back up to a rather congested nursing station for ultimate distribution to the patients. If the School was to develop new educational programs that ensured interaction with professional colleagues as well as with patients, in a good patient care environment, it was quite obvious that the existing service would not be one that could be used. The program grew, a clinical pharmacy program was established with the Department of Medicine, with the support of Dr. Theodore Woodward. This service, which helped to ensure good drug therapy for patients by providing consultative therapeutic services to the medical staff, served as a role model for a clerkship for fifth-year pharmacy students.

The entire drug distribution system was changed. A modern unit dose program was installed in the Hospital, utilizing three decentralized satellite pharmacies servicing certain areas of the Hospital, as well as a main unit-dose pharmacy on the first floor of the new wing of the North Hospital. In addition, the pharmacy took over the preparation of all intra-venous medications to reduce contamination through the use of laminar-flow techniques, and prevent incompatibilities. Patient drug profiles were established in the pharmacy to monitor the patient's drug therapy, and a drug information program was set up to assist the medical and nursing staffs.

The hospital pharmacy program has grown from 1968, when it had six pharmacists, to the present time when 37 pharmacists and 43 technicians operate its program in ambulant and in-patient care. Seven of the pharmacists comprise the clinical pharmacy staff that practice in Medicine, Primary Care, and Family Practice. The program will continue to expand because of the increased demand for its services. It does this in a changing atmosphere within the Hospital, one that is seeing the increased utilization of interprofessional teams in various hospital service areas.

The School has developed other service and educational programs for the State. The Maryland Poison Information Center was transferred from the City Hospitals to the School of Pharmacy in January 1971, and during the first year of operation became the sixth largest poison information center in the United States. During the past year calls have again increased (two fold), and now average 1200 per month. The Center as of July 1, 1974 will have a full-time staff consisting of a Medical Director, a Director (Clinical Pharmacist), and three supportive personnel. The service is maintained in the evenings and on weekends by pharmacy and medical students. The Center serves as an educational center for pharmacy students, and will begin to serve as a nucleus for training of physicians in treatment of ingestions. The School

has been active in drug abuse education program and has established an analytical laboratory to determine the chemical composition of street drug samples that are sent to it. This service has often been useful in reducing the use of street drugs especially when people realize that 65 percent of the street drugs are "mislabeled."

The Faculty of the School has adopted a Doctor of Pharmacy program (Pharm.D.) that is currently being considered by the Board of Regents and the Maryland Council of Higher Education for a beginning date of September 1974. This doctoral program, which is six years in length, will train the highly specialized clinical pharmacist for a role as a consultant to the physician in matters related to drug therapy. This program will be a limited one having approximately 10 students per class in its initial years, and will supplement, not replace, the present baccalaureate program.

The School continues to outgrow its space. In 1957 it occupied Dunning Hall, as well as several floors of the Dental-Pharmacy Building at the corner of Lombard and Greene Streets. Presently, the School occupies the space in Dunning Hall, offices on the first floor of Whitehurst Hall, laboratory and office space on the first floor of what was the old Dental Clinic, and four floors of space in the renovated Allied Health Professions Building (the old Dental-Pharmacy Building). The space is not sufficient for the present School's activities or for future growth, and a new building for the School of Pharmacy is in the planning stage at the present time. It will be built at the corner of Pine and Baltimore Streets in what will then be the complex of the Medical, Dental, and Pharmacy Schools. The School of Pharmacy will then, for the first time in many years, have its own building with adequate space for the operation of its educational programs; in a location that will encourage interdisciplinary work between the other health schools.

The School of Pharmacy at the University of Maryland was established in 1841, making it the third oldest in the nation. It has many great points of history: having the first chair in Pharmacy in the United States; helping found the American Association of Colleges of Pharmacy, and also the American Council on Pharmaceutical Education, the present accrediting body of schools of pharmacy. All of this tradition serves as a base from which has emerged a new school. One that, through its patient care oriented curriculum and involvement with other members of the health professions, is attempting to change the present and future roles of the pharmacist. A change that is difficult and often painful, but will hopefully produce a profession that more effectively delivers its services to the public and to other health care practitioners.

*Ed. Note: Dr. Kinnard is Dean of the School of Pharmacy, University of Maryland at Baltimore.*

# A WORD FROM THE PRESIDENT

William J. R. Dunseath, M.D.

As the University of Maryland Medical Alumni Association approaches its centennial, I would like to share with you some of the highlights of the past year, our accomplishments, our problems, and some suggestions for the future course of the association. There is need for such suggestions, for the association has really been slumbering for a number of years, being maintained mostly by the interest of a relatively small number of its members. As a matter of fact, it is surprising, in view of the relatively low output of the association, that the number of faithful, dues-paying members is as high as it is, but the fact that this number remains respectable speaks well for the potential interest in making the organization worthwhile. There has been a question, over the last few years, that the number of faithful has been diminishing, and this prompted an inquiry, circulated among graduates, by your previous president, as to the reasons for a possible declining interest. Some of the answers have been provocative and are at the base of one or two of the suggestions I will make as I leave office.

In my first communication to you last summer, I spoke of the strong "winds of change" in Baltimore this year, and indeed it has been a year of transitions. At this writing, a search committee is readying its report on recommendations for the post of hospital director. Jack Robinette has held this post on a temporary basis since the retirement of Dr. Yeager, but a permanent replacement will be named shortly.

The other major search committee now meeting, that for a new Dean, also has been narrowing its list of candidates, and will likely be ready to make its recommendations shortly. This committee, chaired by Dr. Edward Kowalewski, Head of the Department of Family Practice at the medical school, is a large committee, and, as one would expect from its size, generates some measure of heat in its ranging. The number of candidates screened approaches two hundred, and judging from the reports of the alumni's representative on the committee, such screening takes considerable time. As some of the outstanding candidates survive the screening procedures and begin to loom as definite possibilities, we hope to have small groups of alumni meet with them individually, and have already done so at luncheon with the first of the front runners.

Meanwhile, John Dennis continues to do an outstanding job in the post, despite the heavy

handicap in recognizing that plans and decisions with far reaching and long term consequences must be rendered with reservations. There is always the possibility that they might encumber a man with a different perspective, who might wind up with the job. There is little doubt that John Dennis recognizes the potential help that an interested alumni might bring, and there is no question that the association could work well with him, were he to take the job permanently.

A number of our alumni, particularly, but not exclusively, among those living and practicing in other states, has expressed some bitterness at the failure of our medical school to accept a son or daughter. I have previously expressed my own opinion concerning the policies of the admissions committee, and it is a measure of Dr. Dennis' willingness to work with the alumni, that he responded to my urging by appointing an alumni representative, in no other capacity than just that, to the committee on admissions. This admittedly will not drastically alter the present policies of the committee, but it does represent a voice to be heard, and that is a beginning. Another dean, less receptive to this alumni's wishes or suggestions, might well have ignored such a request.

We have attempted, this past year, to extend board representation to a wider geographic area, partly in response to suggestions from the membership, and partly as a prelude to hopefully even wider geographic representation, to be proposed later. Unfortunately, in this respect, the energy crisis and accompanying gasoline shortage could not have come at a more inopportune time, cutting attendance of those members of the board from New York, New Jersey and the D.C. area. More about this further on.

One of our largest accomplishments, this year, has been the weighing of anchor of the Davidge Hall project. Your response to this project has enabled us to contract with the architect for the initial survey, leading to historical search, and construction research, which will eventuate in hard facts and figures relative to the actual work to be done, and the priorities to be assigned. The completion of this phase should coincide nicely with the moving of the dean's offices, and the virtual evacuation of the building, except for the alumni offices and some teaching activity, which is to be perpetuated. Kelly Associates of Baltimore is the architectural firm retained to begin the work.

This firm came highly recommended by authorities from the Williamsburg program, and its representatives seem quite excited by the prospect of working on Davidge Hall. It will not be the first time they have engaged in restoration activities. They have as consultant, Orin Bullock, a man who himself has had extensive experience with the work at Williamsburg, and who should fill the role of curator, ensuring the authenticity of the restorative work and furnishings. The roster of the Davidge Charter is growing. What a glorious thing it would be if we had to use the entire side wall of the alumni lounge just to list the members of the Charter!

Finally, the Medical Alumni Association has sponsored functions for both the Senior Class and Junior Class this year. Both functions were well received and well attended. The plan is to continue this as an annual event for the Junior Class, probably in the fall.

So, we have not shaken the world this past year, but neither have we been idle. I have met with other interested alumni locally, and I have made one or two excursions to offices of other medical alumni organizations, and will be making other such excursions. As a result of these discussions, one thing becomes clear. We can proceed along our present course as an association in being, with an office maintaining a roster of graduates, a fairly constant, but small number of which will, by annual payment of set dues, support a secretary or two to keep the office open. We can meet annually, with a banquet to salute those graduates of 50 years standing, and we can meet in small groups, occasionally, at local and national functions of other associations and societies, where we can exchange chit-chat and pleasantries. Or we can reunite and reorganize, with a will, and for the purpose of helping the school which trained us in its efforts to train our successors. In carrying out this purpose we can be of real value to the school, and to medicine, and I believe what most people want is just that—to be of value. I have pointed out earlier, that the best way to attract members to an organization is to make it an organization which is doing something.

For this specific purpose, I will, as I conclude my term as your president, make several recommendations:

*First:* I would recognize all graduates as members, for, in effect, they are all alumni. I would urge that they all be "sustaining members", a designation attained by contributing a stipulated amount, now referred to as dues, for the purpose of carrying out the association's business and stated projects. I earnestly believe we could attract

more participation in this manner, and it is participation we desire, rather than "dues paying members", a term most dues paying members themselves dislike

*Second:* I would establish a sustaining fund (actually built around the Medical Alumni Association Fund into which dues are presently paid) referred to above, into which, in addition to contributions of sustaining members, other alumni so disposed could contribute as they are able, instead of making donations through the general alumni. It may be that their contribution if earmarked for the medical school, do in fact reach the medical school, but, by making donations through the Medical Alumni Fund, identity of such donations from *Medical Alumni* is not lost or clouded. Contributions made through the AMA-ERF can be designated specifically in the way to the University of Maryland Medical Alumni Association Fund.

*Third:* I would enlarge the Board of Directors of the association, and have them meet not more than four times annually, except in special session. I would make their term of office four or five years, electing three new members each year. In this way, representation on the board from other than the Baltimore area would be more feasible, expanding interest and giving a larger source of capable and interested personnel from which to choose. It has been suggested that this expansion might be accomplished by enlarging the nominating committee, but I feel that the proper body to enlarge is the Board of Directors.

*Fourth:* I would establish a body of interested members of *unlimited* number, but definite designation, to be known as an executive committee, or an advisory committee. The name is unimportant, but the function would be to carry out the real business of the association. Divided into groups, or subcommittees, and taking into account geographic areas, this group of groups would execute the various functions of legislative activities, student, and perhaps even prospective student contact, alumni affairs, development and planning, etc. This is the instrument which, I have found, really pulls other alumni associations together, making them dynamic, desirable organizations.

*Fifth:* I would maintain and improve the Bulletin. Even at its worst this publication far surpasses many of the efforts of other alumni groups, and is worthy of our continued support. It is presently published in joint effort and financing with the Medical School and the Hospital, and should be further developed as an organ to keep alumni, and other interested persons, informed of the pro-

part of our Medical School and its activities. We would hope, also, to expand that portion pertaining to alumni activities, including more news of individual alumni. As indicated with the last edition, this phase of our progress is already moving with the distribution of the Bulletin now to all alumni.

Sixth: I would develop an expanded, full-time staff in the alumni office. We struggled along with one executive administrator, and part time secretary help long enough to know that we cannot begin to carry out properly the functions we assign ourselves even now, let alone those which would evolve with any attempt to institute the suggestions I am making here. There are now two full-time people in the office, and I am not at all sure they will be sufficient to carry out the necessary tasks of our present operation. This phase of the

plan should not be difficult to execute, however, though it will be important to the overall success of the association.

I believe that these suggestions are quite feasible, and, if considered seriously, will lead to further measures which will become obvious to those involved. And, as more people become involved, our association cannot avoid becoming the dynamic force to which I have previously alluded. This should not be construed as a wish to make the alumni association a "power". Most of us have no desire for that. But, as a moving agency to aid in furthering the designs of the school in teaching its students, the students in achieving their goals, the Dean in his administration, and the alumni in carrying out these tasks, the association could not avoid becoming an irresistible force, on campus and off.

## Faculty News

### New Appointments, Promotions and Resignations

Valter Urusky, M.D., Assistant Professor — REHABILITATION MEDICINE (promotion effective 1-1-74) 1132 Avenue B, Perry Point, Md. 21902, P.O. Box 42; 642-6029

Joseph B. Bronushas, M.D., Clinical Assistant Professor — FAMILY MEDICINE (appointment effective 1-1-74) 671 Rosalie Ave., Rt. #1, Baltimore, Md. 21221; 687-3295

Sheldon Amsel, M.D., Assistant Professor — MEDICINE (appointment effective 1-1-74) 4420 Wickford Rd., Baltimore, Md. 21210

Vaisami Mohammad, M.D., Fellow — PEDIATRICS (promotion effective 1-1-74) 1005 A. Pleasant Oaks Rd., Parkville, Md. 21234; 828-4844

George M. Meredith, M.D., Instructor — SURGERY (appointment effective 1-1-74) 125 Register Avenue, Baltimore, Md. 21212; 377-0275

Upadee Vorasubin, M.D., Instructor — PEDIATRICS (appointment effective 12-1-73) 2600 W. Patapsco Avenue, Baltimore, Md.; 644-2481

Ming Man, Ph.D., Research Associate — BIOCHEMISTRY (appointment effective 1-1-74) 2405 Kenoak Rd., Baltimore, Md. 21209

Robert Ude, Mr., Assistant Professor — PHYSICAL THERAPY (promotion effective 7-1-74) 2 Durness Court, Baltimore, Md. 21236

Carlos A. Millan, M.D., Assistant Professor — PSYCHIATRY (promotion effective 1-1-74) 1515 Roundhill Rd., Baltimore, Md. 21218; 366-6658

Martha J. McLaney, MSW, Assistant Professor — PSYCHIATRY (promotion effective 7-1-74) 5952 Turnabout Lane, Apt. 12, Columbia, Md. 21044; 730-6908

Judith Armstrong, Ph.D., Assistant Professor — PSYCHIATRY (promotion effective 1-1-74) 108 West 39th St., Apt. 34, Baltimore, Md. 21210; 235-3653

Robert M. Barnett, M.D., Assistant Professor — OB/GYN (appointment effective 2-1-74) 2408 Ravenview Rd., Timonium, Md. 21093; 252-3230

Barry Epstein, M.D., Assistant Professor — MEDICINE (appointment effective 7-1-74) 9215 Three Oaks Drive, Silver Spring, Md. 20901; 585-4866

Horst R. Zielke, Ph.D., Assistant Professor — PEDIATRICS (appointment effective 11-18-73) 6700 Bonnie Ridge Dr., Apt. 101, Baltimore, Md. 21209

Carlos J. Castillo, M.D., Ph.D., Research Associate — BIOCHEMISTRY (appointment effective 1-1-74) 10536 Cross Fox Lane; Columbia, Md. 21044

Jorge R. Ordóñez, M.D., Instructor — SURGERY (appointment effective 2-1-74) 6906 Petworth Rd., Baltimore, Md. 21212; 377-7087

William J. L. Bradley, B.S., Instructor — PHYSICAL THERAPY (appointment effective 2-10-74) 7009 Lachlan Circle, Towson, Md. 21239; 296-6498

Baekhyo Shin, M.D., Assistant Professor — ANESTHESIOLOGY (promotion effective 7-1-74) 533 Wickham Rd., Baltimore, Md. 21229; 525-0136

Carroll W. Hughes, Jr., Ph.D., Instructor — PSYCHIATRY & PEDIATRICS (Joint appointment effective 1-14-74) 5183 Brookway, Columbia, Md.; 730-0578

Gertrud W. Mergner, M.D., Assistant Professor — ANESTHESIOLOGY (promotion effective 7-1-74) 5604 Mirrorlight Place; Columbia, Md. 21043; 730-0683

M. Susan Bollinger, M.D., Associate — MEDICINE (appointment effective 2-1-74) 2703 St. Paul St., Baltimore, Md. 21218; 243-0411

Richard D. Biggs, Jr., M.D., Instructor — MEDICINE (appointment effective 1-1-74) 116 Upnor Rd., Baltimore, Md. 21212; 532-8691

Marguerite T. Moran, M.D., Instructor — MEDICINE AND SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-73) 1520' McElderry St., Baltimore, Md. 21205; 276-7327

Elizabeth I. Knake, Research Assistant — PEDIATRICS (appointment effective 2-3-74) 318 Highland Dr., Apt. 201, Glen Burnie, Md. 21061; 761-3609

Patricia J. Coon, M.S., Assistant — BIOCHEMISTRY (appointment effective 2-14-74) 807 St. Paul St., Apt. 3A, Baltimore, Md. 21202; 547-8670

Neville Brookes, Ph.D., Assistant Professor — CELL BIOLOGY & PHARMACOLOGY (appointment effective 1-1-74) 9654 White Acre Rd., Apt. 6, Dorsey's Forge, Columbia, Md. 21045; 997-2343

Frank H. Figge, Ph.D. (deceased), Professor Emeritus - ANATOMY (appointment 1-74) 4 Maryland Ave.; Towson, Md. 21204

Jordan Edward Warnick, Ph.D., Assistant Professor — CELL BIOLOGY & PHARMACOLOGY (appointment effective 3-1-74)

Thomas H. Wiser, D. Phar., Instructor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-73) 9627 White Acre Rd., Apt. A3, Columbia, Md. 21045; 730-0893

Clarence W. Martin, M.D., Associate — SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-73) RFD 5 Wright's Mill Rd., Baltimore, Md. 21207; 944-1424

Moseley, Jr., Herbert Lee, M.D., Associate — SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-73) 3305 Powhatan Ave., Baltimore, Md. 21215; 383-9493

Lamy, Peter P., Ph.D., Associate — SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-73) 110 Glen Wood Ave., Catonsville, Md. 21228; 747-9576

Wilson, P. David, Ph.D., Assistant Professor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 1-13-74) 806 St. Dunstans Rd., Baltimore, Md. 21212; 323-0092

Robert H. Johnson, M.D., Associate Professor — SURGERY, resigned 7-1-74

Emma J. Flowers, Director — MMTP in PSYCHIATRY, resigned 2-13-74

Maisami Mohammad, M.D., Fellow — PEDIATRICS (promotion effective 1-1-74) 1005 A. Pleasant Oaks Rd., Parkville, Md. 21234; 828-4844

Charles L. Weldon, Mr., Director — METHADONE MAINTENANCE TREATMENT PROGRAM IN PSYCHIATRY (promotion effective 12-31-73) 5436 Jonquil Ave., Baltimore, Md. 21215; 578-0616

Richard P. Buyalos, M.D., Associate — OB/GYN (appointment effective 9-1-73) Hillside Rd, Stevenson, Md. 21153; 484-7023

# **ALUMNI CHATTER**

*Herbert Berger, '32, Staten Island, New York, received the Award of Merit of the New York State Society of Internal Medicine at its annual convention.*



*Richard A. Sindler, '52, Balto., Md., has been appointed Chairman of the Department of Radiology at St. Agnes Hospital in Baltimore.*

In his new capacity, Dr. Sindler is responsible for the professional and administrative management of the Department of Radiology and the X-ray Departments.

Dr. Sindler has been affiliated in a staff radiologist capacity at St. Agnes Hospital since 1958. During this period, he has also served as an Assistant Professor lecturing in radiology at The Johns Hopkins University School of Medicine.

Dr. Sindler received his B.A. degree from Johns Hopkins University and his M.D. degree from the University of Maryland School of Medicine.

He took an internship at Sinai Hospital in Baltimore and completed his Residency in Radiology at Johns Hopkins Hospital.

Upon completion of his residency requirement, he entered the U.S. Air Force serving with the rank of Captain at Clark Air Force Base in the Philippines.

Dr. Sindler is certified by the American Board of Radiology and is a member of the Medical and Chirurgical Faculty of Maryland and the Maryland Radiologic Society.



*Mathew H. M. Lee, '56, New York, N.Y., Director of Rehabilitation Medicine and President of the Medical Board at Goldwater Memorial Hospital, has been promoted to Professor of Clinical Rehabilitation Medicine at the New York University School of Medicine.*

A specialist in geriatrics, Dr. Lee was co-editor with Drs. Arthur Davidoff and Sheldon Winkler of the recent book, "Dentistry for the Special Patient: The Aged, Chronically Ill and Handicapped." He has also written a number of papers on the epidemiology of long-term illness. Recently, Dr. Lee has studied the potentials of acupuncture as a therapeutic technique. He is a member of the Governor's committee to establish standards and directions for acupuncture practice in New York state, and he is active with the Planning Council of the National Institutes of Health. Dr. Lee was a founder and is Secretary of the American Society

of Chinese Medicine. He was also a founder and is now Vice President of the New York Society of Acupuncture for Physicians and Dentists. He recently returned from a five-week trip in Mainland China where he studied acupuncture as a guest of the Medical Association of the People's Republic of China.

He has been an NYU faculty member since 1968, and he is Clinical Associate Professor of Preventive Dentistry and Community Health at the NYU College of Dentistry. He is also an Associate Attending in Rehabilitation Medicine at the NYU Medical Center and attending physician at the Bellevue Hospital Center. In addition, Dr. Lee is medical consultant at the Human Resources Center, Albertson, L.I., and is Secretary of the New York Society of Physical Medicine and Rehabilitation.



*Ralph E. Updike, '62, Ellicott City, Md., has assumed the Presidency of the Medical Staff at St. Agnes Hospital.*

As President, Dr. Updike will chair the hospital's Executive Committee which serves as the governing body of the St. Agnes Hospital Medical Staff.

Dr. Updike, currently Chief of Gastroenterology at St. Agnes Hospital since 1969, received his B.S. degree from the University of Maryland in 1958.

He served a rotating internship at St. Agnes Hospital in 1962-63 that was followed by two years of military service as a Captain in the U.S. Army. Upon being discharged, he returned to St. Agnes Hospital as a Resident in Medicine. This was followed by a two-year Fellowship in Gastroenterology at the University of Maryland Hospital in Baltimore. He completed his post-graduate training by serving as Chief Resident in Medicine at St. Agnes Hospital in 1969.

Dr. Updike holds memberships in the American Medical Association, American College of Physicians, American College of Gastroenterology, American Society for Gastrointestinal Endoscopy and the American Gastroenterological Association. Locally he is a member of the Medical and Chirurgical Faculty of Maryland, Baltimore City Medical Society, Maryland Society of Internal Medicine and the Maryland Society for Gastrointestinal Endoscopy.



*Franklin L. Johnson, '66, Richmond, Va., will be completing his training in pediatric allergy at the Medical College of Virginia in June, 1974, at which time he plans to enter practice in allergy in Salisbury, Maryland.*

## **MEDICAL ALUMNI ASSOCIATION PROGRAM**

**May 29, 30, 31, 1974**

**Wednesday, May 29**      Hospitality Reception and Registration  
Davidge Hall,  
8:00 P.M.

**Thursday, May 30**      **Alumni Day**  
Davidge Hall  
9:30-10:30 A.M.      Registration and Refreshments  
10:30 A.M.      Medical Alumni Assn. Business Meeting and  
                      Medical School Reports  
12:30 P.M.      Luncheon  
2:00-5:00 P.M.      Scientific Sessions  
                      The Bradley Pediatric Society  
                      The Douglass Obstetrical and Gynecological Society  
                      Institute of Psychiatry and Human Behavior  
                      University of Maryland Hospital Medical Association  
                      University of Maryland Surgical Society  
8:00 P.M.      Annual Alumni Banquet  
Main Ballroom  
The Baltimore Hilton

**Friday, May 31**      Pre-Commencement  
Civic Center  
10:00 A.M.

3:00 P.M.      Commencement  
Civic Center

Detailed Programs will be available  
at registration desk

**ALUMNI DAY PROGRAMS**  
**UNIVERSITY OF MARYLAND**  
**HOSPITAL MEDICAL ASSOCIATION**  
**BIENNIAL MEETING**

**Thursday, May 30, 1974**

Engineers Society of Baltimore  
11 W. Mt. Vernon Place  
Baltimore, Maryland

12:30 p.m.	Cocktails
1:30 p.m.	Buffet Luncheon
2:30 p.m.	Business & Scientific Sessions

**Panel**

In Memorial Tribute to  
**FRANCIS J. BORGES, JR.**  
**Chief Resident, 1952-1953**

Moderator: Theodore E. Woodward

"Recent Advances In—

Cardiology	Richard D. Biggs, Jr. St. Joseph Hospital Baltimore, Md. Chief Resident 1969-70
Endocrinology	Francine Camitta Butler York, Pa. Chief Resident 1967-68
Oncology	C. Ronald Koons Boise, Idaho Chief Resident 1961-62
Infectious Diseases	Leonard J. Morse Worcester, Mass. Chief Resident 1960-61
Gastroenterology	W. Carl Ebeling, Jr. Baltimore, Md. Chief Resident 1950-51
The Hospital & Medical School"	Theodore E. Woodward

General Discussion

# **UNIVERSITY OF MARYLAND**

## **SURGICAL SOCIETY BI-ANNUAL MEETING**

**Presiding: R. Adams Cowley, M.D.  
President**

**Thursday, May 30, 1974**

8:30 a.m.-12:30 p.m.	GENERAL ALUMNI SESSION
12:30 p.m.-2:00 p.m.	Luncheon—Alumni Lounge Student Union
2:00 p.m.-5:00 p.m.	Scientific Session—Gordon Wilson Hall

**Friday, May 31, 1974**

8:30 a.m.	Coffee & Donuts
9:00 a.m.-10:30 a.m.	Scientific Session Gordon Wilson Hall
10:30 a.m.-11:00 a.m.	Coffee Break
11:00 a.m.-12:00 noon	Scientific Session
12:00 noon-1:00 p.m.	Bi-Annual Business Meeting
1:00 p.m.-2:00 p.m.	Luncheon—Gordon Wilson Hall
6:30 p.m.	Buses Leave University of Maryland Hospital—Circular Driveway
7:00 p.m.	Cocktails—Baltimore Country Club Five Farms
	Dinner-Dance to Follow

# UNIVERSITY OF MARYLAND PEDIATRIC SOCIETY

## BRADLEY PEDIATRIC SOCIETY PROGRAM

**Thursday, May 30, 1974**

Room 202 Student Union Building

Presiding: George A. Lentz, Jr., M.D.

2:00 p.m.	Welcome Marvin Cornblath, M.D. Professor & Chairman Department of Pediatrics
2:05 p.m.	"Impact of an Accident Upon the Sibling Accompanying an Injured Child" Theodore H. Kaiser, M.D.
2:20 p.m.	"Growth Standards for Inner City Black Children with a Note on Low Birth Weight Infants" Prasanna Nair, M.D. Ray Hepner, M.D.
2:35 p.m.	"Regionalization of Child Development Services in Maryland" Oscar C. Stine, M.D.
2:50 p.m.	"Endocrine Evaluation for Short Stature—Who?" Salvatore Raiti, M.D.

### COFFEE BREAK

Presiding: Raymond Clemmens, M.D.

3:15 p.m.	"Evaluation of the Allergic Child— Referral Mechanism and Follow-up" Tsau-Yuen Huang, M.D.
3:30 p.m.	"Cardiac Referrals for Diagnosis and Treatment—Newborns" Robert Gingell, M.D.
3:45 p.m.	"Intensive Care Nursery at University of Maryland Hospital— Experiences" Ronald Gutberlet, M.D.
4:00 p.m.	"Pediatric Nephrology—Recent Studies at Maryland" Edward Ruley, M.D.

# **DEPARTMENT OF PSYCHIATRY**

**Institute of Psychiatry and Human Behavior**

**Thursday, May 30, 1974**

**Room 1-704**

**Moderator—Russell R. Monroe, M.D.,  
Acting Department Chairman**

1:30 p.m.	Introductory Remarks Russell R. Monroe, M.D.
	"A Potential UMAB Identity: Inter-school and Inter-departmental Collaboration in Social and Behavioral Studies" Eugene B. Brody, M.D.
	"Developments in the Division of Child Psychiatry" Stanford Friedman, M.D.
2:30 p.m.	COFFEE BREAK
2:45 p.m.	"Development of a Violence Clinic" John Lion, M.D.
3:30 p.m.	"Effects of Human Contact on the Cardiac Activity of Coronary Care and Shock Trauma Unit Patients" James Lynch, Ph.D.
4:15 p.m.	"The Etiology of Compulsive Drug Use" Leon Wurmser, M.D.
5:30 p.m.	Cocktails—Holiday Inn Lombard Street (cash bar)

---

## **THE DOUGLASS OBSTETRICAL & GYNECOLOGICAL SOCIETY**

**Thursday, May 30, 1974**

**Conference Room**

**9 East North Hospital Bldg.**

**(Rm. 9-1201)**

1:00 p.m.	Hospitality
2:00 p.m.	Obstetrical Case Report— "Use of Oxytocin Challenge in Management of High Risk Pregnancy"
3:00 p.m.	Gynecological Case Report— "Management of Small Adnexal Masses"



## *DAVIDGE HALL IS A PRICELESS HERITAGE —SUPPORT ITS RESTORATION!*



When originally constructed, the building now known as Davidge Hall included a "Blue Room" where, for an extra fee, students could meet with faculty members for conferences and special tutoring. Plans for restoration would find the "Blue Room" reappearing, again to be used as an informal conference room, by students, faculty, and alumni. Restoration will not only enhance the beauty of this venerable structure, it will expand its usefulness to the entire Baltimore campus. It will continue to be the "oldest medical school building in the Western Hemisphere in continuous use for the teaching of medical students."

Lend a hand in the restoration of this authentic piece of Maryland and medical history. Send your contributions to the Davidge Hall Restoration Fund c/o Maryland Medical Alumni Association, 522 West Lombard Street, Baltimore, Md. 21201.

# ALUMNI NEWS REPORT

## TO THE BULLETIN:

I would like to report the following: \_\_\_\_\_

---

---

---

---

---

---

---

---

---

---

---

---

## **SUGGESTIONS FOR ITEMS**

- American Board Certification
- Change of Office or Address
- Residency Appointment
- Research Completed
- News of Another Alumnus
- Academic Appointment
- Interesting Historic Photographs and Artifacts
- Scientific Articles

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Class \_\_\_\_\_

Send To: George H. Yeager, M.D.  
Editor, Alumni Bulletin  
University of Maryland  
School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Maryland 21201

# Bulletin

univers

Aug 13



ISSUE

editorial board

George H. Yeager, M.D.  
(*editor*)  
Mary A. Lantz  
(*editorial assistant*)  
George Entwistle, M.D.  
Robert B. Goldstein, M.D.  
Donald T. Lewers, M.D.  
Joseph S. McLaughlin, M.D.  
Frederick J. Ramsay, Ph.D.  
Elijah Saunders, M.D.  
W. Douglas Weir, M.D.  
John M. Dennis, M.D.  
(*ex-officio*)  
William J. R. Dunseath, M.D.  
(*ex-officio*)  
Jack C. Robinette  
(*ex-officio*)

# Bulletin

**university of maryland school of medicine**

August, 1974

Vol. 59

No. 3

<b>John M. Dennis, M.D.—Dean</b>	<b>2</b>
<b>Department of Pediatrics—University of Maryland Hospital</b>	<b>3</b>
<b>Progressive Dental Hygiene Education at U. of Md.</b>	<b>27</b>
<b>President's Message</b>	<b>29</b>
<b>Gold Key 1974</b>	<b>30</b>
<b>Alumni Day 1974</b>	<b>31</b>
<b>Class of 1974</b>	<b>33</b>
<b>Faculty News</b>	<b>34</b>
<b>Alumni Chatter</b>	<b>36</b>
<b>Necrology</b>	<b>39</b>
<b>Alumni News Report</b>	<b>40</b>

# **ficers and Board Directors of the Medical Alumni Association 1974-75**

**PRESIDENT**  
Robert B. Goldstein, M.D. '54

**PRESIDENT-ELECT**  
William H. Mosberg, Jr., M.D. '44

**VICE PRESIDENT**  
Benjamin M. Stein, M.D. '35

**VICE PRESIDENT**  
J. T. Mendez-Bryan, M.D. '51

**VICE PRESIDENT**  
John H. Hornbaker, M.D. '30

**SECRETARY:**  
Kyle Y. Swisher, Jr., M.D. '48

**TREASURER:**  
John F. Strahan, M.D. '49

**MEMBERS EX-OFFICIO:**  
John M. Dennis, M.D. '45  
Henry H. Startzman, Jr., M.D. '50  
William J. R. Dunseath, M.D.

**MEMBERS OF THE BOARD:**  
Matthew R. Donohue, M.D. '64  
Miles E. Drake, M.D. '44  
Joseph D'Antonio, M.D. '46  
James A. Roberts, M.D. '46  
Herbert J. Levickas, M.D. '35  
J. I. Cornbrooks, Jr., M.D. '35  
mond J. Donovan, Jr., M.D. '58  
Wallace H. Sadowsky, M.D. '42  
Robert T. Singleton, M.D. '53

**EXECUTIVE SECRETARY:**  
Mrs. Jean D. Goral

## **Information for Contributors**

**CONTRIBUTIONS:** Original typed copy, not carbon copies, and illustrations, requests for exchanges and book reviews, should be forwarded prepaid at the author's risk to the Editor of the University of Maryland School of Medicine Bulletin:

George H. Yeager, M.D., Editor  
Alumni Bulletin  
University of Maryland School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Md. 21201

**PREPARATION OF MANUSCRIPTS:** Manuscripts, including references, should be typed double spaced on one side of the paper, leaving wide margins. While every effort will be made to guard against loss, it is advised that authors retain copies of manuscripts submitted. All pages should be numbered. Numbers one to ten should be spelled out, except when used for all units of measurement (time, dimension, degrees, weight, volume, dosage, etc.), percentage, and decimals; for numbers above ten, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized. Units of measurement, e.g., dosage, should be expressed in the metric system. Temperature should be expressed in degrees centigrade. Contribution in a foreign language, when accepted, will be translated and published in English.

**PREPARATION OF ILLUSTRATIONS:** Black and white illustrations will be reproduced free of charge, but the publisher reserves the right to establish a reasonable limit upon the number supplied. Colored illustrations will be published at the author's expense. Black and white photographs should be presented as glossy prints. Line and wash drawings should be black, on white paper, with lettering in black India ink, large enough to be readable after necessary reduction. Large or bulky illustrations should be accompanied by smaller glossy reproductions of the same, to facilitate their circulation among the judging members of the editorial board. Illustrations should be numbered, the tops indicated, and the author's name and the title of the article in brief should appear on the back. A separate typewritten sheet of legends for the illustrations should be supplied.

**REFERENCES:** A bibliography of numbered references in alphabetical order should appear at the end of the manuscript with corresponding numbering in the text. Bibliographies should conform to the style of the Index Medicus with the exception that the last page number should be omitted, viz: author's name, title of article, name of journal, volume number, first page number, and year of publication in the order named.

### **INFORMATION FOR SUBSCRIBERS**

The University of Maryland Medical Alumni Association Bulletin is the official publication of the University of Maryland Medical Alumni Association and is published jointly four times annually by the University of Maryland Medical Alumni Association and the Faculty of the University of Maryland School of Medicine. Subscription price is \$5.00 per year in the United States, Canada and Mexico; and other countries \$6.00. Single copies, current and back copies, if available, are priced at \$2.00.

**CHANGE OF ADDRESS:** Please allow 60 days before date of issue for change of address. Notification should include the old as well as the new address (include Zip Code) with indications of whether the change is temporary or permanent. Please give the name of the journal. Copies will not be replaced without charge unless we receive a request within 60 days of the mailing in the U.S. or within 90 days in all other countries.

Membership subscriptions (University of Maryland Medical Alumni Association) and business relating to membership should be sent to: University of Maryland Medical Alumni Association, University of Maryland School of Medicine, Room 201 Davidge Hall, 522 W. Lombard Street, Baltimore, Maryland 21201.

The Publishers accept no responsibility for opinions expressed by Contributors.

# **University of Maryland School of Medicine**



## **JOHN M. DENNIS, M.D. DEAN**

The Board of Regents of the University of Maryland, on May 17, 1974, appointed Dr. John M. Dennis as Dean of the University of Maryland School of Medicine. Dr. Dennis brings to the Dean's office a broad experience in the problems of medical education, hospital administration and patient care. In addition, he has been involved in the activities of organized medicine at both the local and national level.

A native of Wicomico County, Maryland, Dr. Dennis received his B.S. degree in 1943 and his M.D. degree in 1945, both from the University of Maryland. Following active duty in the U.S. Army, he completed his graduate training in Radiology at the University of Maryland and the University of Pennsylvania Hospitals. In 1951 he joined the faculty of the University of Maryland School of Medicine, and in 1953 he became the first full-time departmental Chairman in the school.

Currently, Dr. Dennis is Vice Chairman of the Board of Chancellors of the American College of Radiology, a member of the Board

of Trustees of the American Board of Radiology, a member of the Scientific Advisory Board of the Consultants of the Armed Forces Institute of Radiology and a member of the Board of Managers of The Union Memorial Hospital.

The appointment of Dr. Dennis as Dean has brought enthusiastic endorsement. Medical education, to meet current and future demands, requires a stable solution to its problems. Delineation is required from the viewpoint of (a) defining the function of medical schools; (b) clearly stating the role of University centers and community hospitals in graduate medical education; (c) the responsibility of each in delivering health care. Teaching needs must continue to be the primary basis for judging the extent of community service that is rendered. Medical education, to meet current and future demands, requires a sound solution to its problems. The experience and background of Dr. Dennis has prepared him exceptionally well to objectively approach these problems.

# University of Maryland Hospital

## DEPARTMENT OF PEDIATRICS

We wish to express our appreciation to Doctor Alexander J. Schaffer who coordinated, coerced, and edited the story of the Department of Pediatrics. Without his gentle persuasion, firm determination and eminent skill as an editor and author, this presentation would not have been possible.

### INTRODUCTION

Marvin Cornblath, M.D.

As the Department of Pediatrics of the University of Maryland School of Medicine & Hospital, our aims are to provide the best possible education to all students and residents for the concerned care of children and to provide the best health care for the children of Maryland in all ways in our power. This is accomplished not only by direct care but also by support to the physicians and pediatricians throughout the state so that they may do their job in the most effective and useful manner. Our services are dedicated to all children, whatever their needs may be. This broad challenge is manifested in a number of ways, from primary care of the well child, to the most intricate and complicated diagnostic and therapeutic manipulations within the hospital setting. No one of these has merit above the others, but all strive together to provide a broad educational environment for the undergraduate student, the house officer and the pediatrician throughout his professional career.

Our outreach has continued in the tradition of Dr. Bradley, the first full-time head of the Department of Pediatrics, who himself established community pediatric residencies with affiliated hospitals over a decade ago. Building on his firm base, we have extended our programs and services into the entire city and state, participating in medical care as far away as at the School for the Blind, and in Allegany and Garrett Counties (Appalachian program), while at the same time performing the most sophisticated research on molecular biology. All in all this is achieved within a academic environment which according to my definition merely reflects the physician or the student who is constantly questioning what he is doing, why he is doing it and if there could be a better way to do it. Thus, the academic physician exists both within and without the School of Medicine, and the term is unrelated to one's position, method of pay-

ment, or title. It is the physician who is truly dedicated to the welfare of children and performs whatever his tasks may be to the utmost of his ability.



The helicopter has just landed on the helipad. A tiny sick premature infant in his warmed oxygenated transport carrier is being hurried to the Newborn Intensive Care Unit.

### NEWBORN CARE

Ronald L. Gutberlet, M.D. & Prassanna Nair, M.D.

Despite the drop in birth rate in Baltimore City from 22,000 in 1963 to 12,000 in 1973, the drop in the number of births at the University of Maryland Hospital has been less precipitous, going from a stable number of 2400 per year to 2290 in 1973.

Term, well newborns are admitted to the Full-Term (FT) Nursery, and placed in radiant heated beds or incubators, and vital signs monitored closely under a transitional care concept. After stabilization, the infant goes to the mother. Rooming-In schedules are flexible, and depend on both mother and infant needs. All at-risk deliveries are attended by a Pediatric house officer, and all infants are examined within 12 hours after birth. Repeat physicals are done on discharge at the mother's bedside to encourage reporting of findings to the mother and instruction in home care.

Infants developing problems other than mild to moderate jaundice are transferred to the Intensive Care Nursery (ICN). Approximately 12% of our newborns are low birth weight (2500 gms.). This is high for U.S. standards, but is representative of the high-risk population served by the University of Maryland Hospital.

There are approximately 350 admissions to the ICN each year, and this includes 90-100 infants

transferred from other hospitals. Other than prematurity, respiratory distress is the most common problem. Birth asphyxia also accounts for many admissions.

The University of Maryland Hospital ICN with the Baltimore City Hospitals ICN constitute the Regional Intensive Care Nursery (RICN) of the State of Maryland. During the past 2½ years, 115 babies were transferred from 9 Baltimore area hospitals, and 122 infants from 22 out-of-town hospitals including several from Pennsylvania and West Virginia.

Within the past three years, we have discovered three new metabolic diseases that had not been described previously. In the same time, we expanded services to children with behavior and learning disorders in over 18 schools in the Western Health District. Over the same years, we have provided comprehensive services to over 10,000 children registered at our Community Pediatric Center. Annually, we have had a one-day post-graduate course on problems related to the welfare of children and adolescents. The registration has ranged between 150 and 200 participants, including teachers, psychologists, social workers, pediatricians, family physicians and educators interested in children. Each of these achievements reflect the collaborative, whole-hearted effort of every member of the department, each devoted house officer and the support of every other professional group within the department and the School of Medicine. Each of these achievements is equally precious and one does not outweigh the other. Whether one looks after the minor acute illness of the child with love, tenderness, expertise and diligence, or whether one describes a new metabolic pathway or enzymatic defect for a new disease, both are equal in the eyes of this Department of Pediatrics. To take everything seriously but oneself is our motto, and our goal is to render the utmost of ourselves to anyone who seeks our services, be he newborn, infant, child, adolescent, parent, or physician—that is our ultimate achievement.

## INPATIENT CARE

The conventional supremacy of the inpatient services within a medical school-hospital facility is being challenged. We think the body of this article will demonstrate why this is so. Nevertheless, the care of very sick infants and children by a team of maturing and mature residents, supervised by dedicated senior teachers and sub-specialists, remains one of our most satisfactory health care devices and teaching tools.

A great deal of nursing and house staff time is spent in counselling parents, and in ensuring that every opportunity is made available for visitation of the child in the nursery. Physical contact with the baby is encouraged, including those babies on respirators. A social worker and a public health liaison nurse are available for consultation both for babies in town and from out-of-town. A log is kept while babies are in the nursery as to the number of times the family has visited. A check list before the infant is discharged includes such items as the ability of the mother to feed the infant, and to care for him in the home situation.

Infants transferred from out-of-town usually arrive via helicopter. Any hospital in Maryland is less than 1 hour away by this mode of transport. The infants arrive in transport Isolettes supplied by the Regional Intensive Care Nursery, accompanied by a physician and/or a specially trained State Police corpsman. A great deal of effort is spent in keeping the referring physician informed of the baby's progress while a patient is in the nursery. In addition, the family is frequently contacted, and upon discharge, a summary is sent with the patient. Infants transferred to the nursery from the hospitals in Baltimore City are transported by the Baltimore City Fire Department. The ambulance comes to University Hospital, picks up the transport incubator as well as a house officer, goes to the referring hospital, and our care of the baby is assumed at that point.

To care for the infants in the nurseries, there are 14 nursing personnel for the Full Term (FT) nursery, and 24 for the Intensive Care Nursery (ICN). Physician coverage is provided by 4 Pediatric house officers, a Senior Medical Student, a neonatology fellow and a neonatologist available full time. Pediatric subspecialty consultation is widely used, and full-time Pediatric Cardiovascular and General Neonatal Surgeons are now at the University of Maryland Hospital.

Most acutely ill newborns are admitted to radiant heated infant intensive care beds. A monitoring system recently installed gives continuous heart and respiratory rate, temperature, and blood pressure measurements on up to 6 infants at a time with a central alarm system. This is in addition to isolated electronic monitoring systems. Extensive physiological and biochemical monitoring is done. Examples of procedures done on 166 admissions over the past 6 months include 65 umbilical artery catheterizations; 31 umbilical vein catheterizations; 14 infants received nasal or endotracheal continuous positive airway pressure; 30 required respirator support; and 64 patients had at least one sepsis work-up.

Babies that are stable may be transferred eventually to the well baby nursery, back to the referring hospital, or sent home. There is no weight limit for discharge from the nursery. The basic criteria to be met are that the infant is stable in a bassinet in room air; that he is eating a formula easily obtained and at a frequency that can be handled by the mother; that it has been established that the home is ready for the baby; and that the mother has had experience with the infant in the nursery. Most small prematures have reached 4½ lbs. before these criteria are met.

Many concepts of neonatal intensive care still need to be evaluated as to their influence on survival and outcome. There is therefore extensive record keeping both in the infant's chart, as well as other logs including punch cards and composite flow sheets. As concepts of care in the neonate are constantly changing, protocols for care also are continually changing. Continuing education of the medical and nursing staff is critical.

As part of the evaluation process, an ICN follow-up clinic meets each Wednesday afternoon where 20 to 40 infants are seen by the nursery staff to evaluate growth and development as well as provide primary care for this group of high risk infants.

Held in the University of Maryland Community Pediatric Center, excellent follow-up is obtained through its Public Health Nursing staff. Infants from out-of-town are seen by their local physicians who provide information on outcome, as well as permitting periodic visits to Baltimore for follow-up evaluation.

Clinical studies involving appropriateness of and development of new care are part of the ICN function. The following are examples of studies currently being conducted:

1. Mechanisms involved in the inability of sick premature infants to utilize carbohydrate. This study is supported in part by the Mead-Johnson Co.

2. The utilization of other substrates in the newborn diet, i.e. alanine.

3. Cardio-respiratory patterns during sleep in infants and their possible role in the Sudden Infant Death Syndrome. Support from this study comes from the Infant Fight for Life Organization, Inc., The Charles W. Ardrey Memorial Child Welfare Trust Fund and from Mr. and Mrs. William W. Cobey, via the Mary Gray Monroe Memorial Fund. We are grateful to them.

While preliminary data indicate that ICN's are having an effect of decreasing neonatal mortality and decreasing long-term morbidity, full-scale evaluation is needed. The process in Maryland has

begun, including evaluation of the regionalization of care. Through these evaluations, the nurseries of the University of Maryland Hospital will continue to modify, update, and improve newborn care.

## INFANT AND CHILD INPATIENT CARE

*Stephen Dubansky, M.D. & Harold Magalnik, M.D.*

The inpatient service for children is divided by age: Infants after the newborn period to 3 years of age are on 5E; children from 3 to 10 years of age on 5B. Adolescents will be discussed later. Together, these first two services can accommodate 44.

When a child is admitted to the Pediatric floor, a complete examination is done by our house officers. This procedure is followed for both medical and surgical patients. All children younger than 2 years of age are admitted to the medical service with the surgeons acting as consultants.

The patient's stay in the hospital is made as comfortable as possible due in large measure to an active child-life program—one program for each of the wards. The program for the younger children concentrates on visual and motor stimulation, while the older children are provided with a typical nursery school program. Hospitalization is a trying time for both children and families. Therefore every effort is made to make the experience as positive and non-threatening as possible. We encourage frequent visits and allow brothers and sisters to visit their hospitalized siblings. The parents are also encouraged to stay with the younger child so that feeding and mothering routines may be continued.

The diseases seen in the in-patient service mirror are those seen in any large city hospital and referral center. At any one time, the entire spectrum of diseases, from the most common to the most esoteric, can be seen on the wards. The variety of admissions to the wards has been a reflection of the growth of each pediatric subspecialty. Each ward service is staffed by a third-year resident and two or three less-advanced residents. The primary responsibility for direct patient care lies with the latter, who are supervised by the senior resident. Junior and senior medical students are on the wards during the entire academic year. Each medical student has one house officer as his preceptor and works in conjunction with this individual in the work-up and care of patients.

The four bed pediatric intensive care unit provides both medical and surgical patients with the close, minute-to-minute management required for the critically ill child. The talented and dedicated nursing staff is adept in dealing with the physical and the emotional crises of their patients, whether infants, children, or adolescents.

Medical supervision of the house staff is provided by the third-year teaching resident as well as a senior attending pediatrician and the appropriate subspecialists. The newly remodeled, spacious unit on the 5D ward has sophisticated equipment for intensive care monitoring and emergency care intervention. Respirator care, peritoneal dialysis, exchange transfusion, cardiac pacemakers—all are handled with competence by the nursing and pediatric staff. Support from surgical specialists, anesthesiologists and physical therapists is readily available. The Department of Pathology has been most cooperative in providing instant metabolic autopsies when indicated. Present plans call for continued expansion of the unit on the D wing, with the addition of contiguous self-care rooms for cardiac catheterization and renal biopsy patients.

The Pediatric Continuity Clinic was established in July, 1973, to provide the pediatrician in training with the invaluable experience of long-term ambulatory patient care. Presently, well over 150 infants, children, and adolescents are enrolled in this clinic. The house staff is divided into five teams, each team having one clinic day, where its members can see their patients by appointment.



*Dr. Cornblath examining a little patient on Ward E, with the prescribed quantity of Love, Concern, and Excellence.*

When a patient's primary physician is unable to see his or her patient, another member of the team does so. Consultations are available with all of the department's specialists, but no matter how complex and multifaceted the child's problems, the house officer who is his or her physician, takes primary responsibility for the care. Besides patients requiring sophisticated metabolic, renal, hematologic, and behavioral expertise, there are many well children with normal development who are cared for. Immunizations are given and home visits are encouraged. Working together with a public health nurse, clinic nurse, social worker, and the secretary, the house staff gains an ap-

preciation for the increased efficiency of team health care delivery. The parents and their children gain the immensely important advantage of relating to a single physician who knows "the whole patient."

Future plans include expansion of the physician's supporting staff, and the supervision of each team by a pediatric generalist who will stay with the team for the three-year period covering the house officer's training.

Love, concern, and excellence is the Department's motto. We expect the care to be excellent, and the staff's attitude and performance to demonstrate love and concern. Each child is special to us. We attempt to meet the child's needs on a individual and humanistic basis, with the patient's medical interest of primary concern.

#### **CARE OF ADOLESCENTS**

*Felix P. Heald, M.D.*

Specific interest in adolescent medical care did not begin until 1951 when the first adolescent medical clinic for ambulatory patients was opened at the Children's Hospital Medical Center, Boston. In 1959, the first adolescent inpatient medical facility opened at Children's Hospital of Cincinnati. In January 1968, there were 24 non-psychiatric adolescent wards reported and there may be twice as many now. In 1972, the availability of space in the new addition to the University Hospital allowed the establishment of a Division of Adolescent Medicine. In October of that year, the 11-bed adolescent inpatient unit was opened on 5-C Wing of the old hospital, then was relocated on 8-West when the new wing of the hospital was opened in April 1973. It was expanded to 27 beds in March 1974 with all teenagers requiring hospitalization in the University Hospital being admitted to this new facility.

In 1971, Rigg and Fisher attempted to evaluate the desirability of an adolescent inpatient unit. The unit directors felt that their program made a particular contribution to the overall teaching program in addition to providing better continuity of care. They also felt that multidisciplinary rounds resulted in better staff training and better coordination of patient care. Nurses interviewed noted that although discipline was the primary problem in the unit, the advantages of the separate unit outweighed the problems. The patients themselves reacted favorably to the good staff communication, good recreational facilities, presence of peers and the "special" ward.

No significant data has been formulated in regard to types of patients which are appropriate for the inpatient adolescent unit. We feel that all units should be able to provide care for the acute, sub-

acute and chronically ill adolescent excepting chronic drug abusers, severely emotionally disturbed patients (acute psychoses and suicidal patients) and third trimester obstetrical problems.

In a multi-service adolescent inpatient unit the surgical services usually account for 60% of the inpatient beds. The kinds of patients that are admitted to a general adolescent service can be divided into three categories:

Acute care—A wide variety of medical and surgical problems, none found only in the teenager, are admitted to such an inpatient service. Included in acute admissions will be drug overdoses and suicidal patients. A special program to aid the suicidal teenager has been funded by the Thomas Wilson Foundation. Their initial admission to an intensive care unit or teenage medical unit is appropriate. After the medical emergency has subsided, then the appropriateness of continued care of such patients in an open medical ward must be settled. Frequently, psychiatric consultation is necessary to facilitate both the decision and the transfer of such patients to a more suitable facility.



*The recreation room of the Adolescent Department. This is an unusual view. Most of the time the room is the scene of unbridled activity.*

Chronic care—By the second decade of life, there is a small but important group of youngsters who are chronically ill and periodically require hospitalization. These teenagers require considerable supportive care to help them understand their reactions to chronic illness. Knowledge of the developmental aspects of adolescence is particularly helpful in supporting these youngsters.

Finally, there is a group of teenagers with diagnostic problems which frequently fall into the psychosomatic category. When such youngsters are located on a teenage ward, observations on the relationship between behavior and symptomatology by observers trained in the developmental aspects of adolescence is frequently of considerable aid in arriving at the correct diagnosis.

The major role that nursing personnel can effect in a general adolescent ward is supporting teenagers as they react to their illness. Special knowledge of the developmental aspects of adolescence is particularly useful in interpreting hospitalization and teenage behavior. A thorough explanation for any procedure being done to a teenager, the interpretation of results of blood tests and x-rays reduce their uncertainty and make them feel a part of the medical team. After all, it is their body and they deserve to know what's being done and what's wrong with their body.

The adolescent inpatient unit at University of Maryland Hospital provides care to pre-adolescents and adolescents (ages 10-18 years old). Although individual services admit and manage patients separately, all patients are followed by the adolescent care team stationed on the floor. This team consists of physicians (residents and interns and fellows from the Departments of Pediatrics, Internal Medicine and Family Practice), nurses (coordinated by the Nurse Chairman Ms. Marilyn Aten, trained in depth in adolescent nursing), psychologists, psychiatrists, social workers, recreation and program specialists, as well as a public health nurse and a nutritionist. Attendings are provided by the Departments of Pediatrics, Psychiatry and Internal Medicine. All patients participate as fully as they can in the programs of the unit in addition to their prescribed therapy. Programs include recreation, tutoring, education, and peer group interaction for the early and older adolescent.

## **BEHAVIORAL PEDIATRICS**

*Thomas J. Kenny, M.D.*

The practice of pediatrics has a need to further recognize the psychologic and social aspects of normal and abnormal development. Pediatrics must develop an interest in the prevention of social, emotional, and educational problems of children. Traditional training programs stress the management of exotic illness but provide limited training in understanding the multiple interactions between physical disease and psychological development. Recognizing this problem, the Department of Pediatrics is beginning a service and training program to meet these needs.

The behavioral pediatric admission program evolved out of a recognition for the need for this service. A survey of pediatricians, child psychiatrists, and social agencies in Maryland indicated an overwhelming interest in having a resource for children experiencing problems involving behavior, learning, and psychologic aspects of illness.

The "Behavioral Admission" is seen as a short-term hospitalization ranging from a few days to ninety days which would provide comprehensive diagnostic services and short-term treatment programs. Referrals would come from physicians including pediatricians and child psychiatrists, or parents acting in conjunction with recommendations from physicians, schools, or social agencies.

Special personnel would be available to see children who manifest emotional or educational problems or who are having difficulty adjusting to physical illnesses. On admission, the child could be seen by a full team of specialists including the pediatrician, child psychiatrist, pediatric psychologist, social worker, nurses, and education specialists including language pathologists and diagnostic teachers.

A short-term admission of the child allows for extensive evaluations to be accomplished with greater efficiency. In addition to facilitating the evaluation, the admission would provide a better opportunity for planning and instituting treatment programs. For example, chemotherapy is best carried out with the benefit of close observation of the initial response. Similarly, an intense, initial involvement is beneficial at the start of psychologic treatments such as psychotherapy, behavior modification, or parent counselling. In addition, the separation from the environment provides a period of time for the family to reorganize and provides a fresh start for family members.

The types of patients served by behavioral pediatrics will be varied, including children with uncontrolled diabetes, complex seizure disorders, endocrine disorders, problems of atypical growth, and behavior or learning problems.

As an example of the service provided, a 15-year-old boy with a long history of uncontrolled diabetes was referred for consultation. The boy had a dozen hospital admissions in the previous ten month period. In the hospital the boy responded to treatment but when he returned home, he deteriorated rapidly and frequently went into ketoacidotic coma. The behavioral consultation focused on the boy's family problems and began counselling the boy while he was in the hospital. After discharge, the patient was followed for outpatient counselling for six months. Since the Behavioral Consultation and intervention, the boy has not had a diabetic crisis requiring hospitalization.

In addition to meeting pressing service needs, the Behavioral Admission will add a needed dimension to training the Pediatrics House staff. Beginning in July, 1974, there will be two Be-

havioral Pediatric fellows who will work with the program. These fellows will provide consultation to the Pediatric House staff and nursing personnel. The training experience will involve the combined staffs of the Department of Pediatrics, Child Psychiatry, and Pediatric Psychology.

The resources of the Behavioral Pediatric program will not be confined to specific patients but will help set an atmosphere for maximum attention to the therapeutic milieu of the hospital ward. In this way, the availability of behavioral consultations and staff conferences will benefit the total inpatient service as well as the house staff and ward personnel.

## OUTPATIENT SERVICES

More and more emphasis is being directed toward supplying and teaching proper care in ambulatory settings. Within the hospital environment outpatient facilities have been steadily augmented, while equipment, supervision and consultative expertise have been improved *pari passu*. These changes have resulted in sharp reductions in morbidity and hospital admissions.

### GENERAL O.P.D. AND E.R.

*Philip J. Jensen, M.D.*

The Pediatric Clinic was originally located in the basement of the old Medical School library and remained there until 1934 when the University Hospital moved into the present main hospital building. The Pediatric Clinic then took over the B & O ward on the first floor of the old hospital at Greene and Lombard Streets and remained there until 1973 when it was again moved to the fifth floor of the North Hospital building. There were no specialty clinics until 1949 when Dr. Ruth Baldwin started the Exceptional Child Clinic.

From 1921 to 1944 the Director of the Clinic was Dr. E. Loring Joslin. Since 1944, Dr. Abraham H. Finkelstein has been the Director of the Clinic with Dr. Samuel Shipley Glick being his Assistant Director for most of this time. Since 1961, the Assistant Director has been Dr. Philip J. Jensen. Dr. Martin Wasserman will become the new co-director of the Clinic on July 1, 1974.

The total number of patients seen in the clinic in 1916 was 1,536, of whom 605 were new patients. During the year 1973-1974 this number had risen to approximately 30,000.

The new quarters of the Pediatric Clinic, general and specialties, now occupy a large area of the fifth floor of the new North Hospital building. The general pediatric area occupies a central area in which there is a consultant and nursing area surrounded by examining rooms to which the pa-

tients gain access from an outside corridor. The area is so set up that it can operate efficiently as an emergency room during the evenings and nights and on weekends. Only trauma cases and catastrophic emergencies are seen in the adult emergency room on the ground floor. The clinic also acts as a pediatric emergency room during the day.

The general specialty clinics occupy a long corridor with adequate examining and consulting rooms and secretarial space. The Exceptional Child Clinic and the Central Evaluation Clinic for Children occupy multiple-roomed areas which are conveniently located nearby.



Dr. Mike Fox examines a well-behaved little fellow in the O.P.D. while his family and a nurse look on approvingly.

Third-year students rotate through the outpatient department every three weeks throughout the school year under the supervision of a group of dedicated consultants, many of whom are pediatricians in private practice. They also acquire experience in the emergency treatment of patients when on call, under the supervision of the house staff. Often there are one to two fourth-year students working in the clinic on an elective basis.

There are usually six to eight house officers manning the pediatric clinic, assigned either to the screening, acute care or appointment areas. While on the clinic service the house officers are under the supervision of a coordinating resident who is responsible for the smooth flow of patients.

The new pediatric facilities in the North Hospital building are a far cry from the old clinic which occupied the old B & O ward, constructed in 1875. In spite of its age, murals of animals on the walls and in recent years various pastel shades of color applied by members of the department helped to brighten the area. The specialty clinics were located in the basement with the Exceptional Child and Central Evaluation Clinics. However, the Della

## SPECIALTY CLINICS

One by one since 1949 additional special clinics have been established. The number has by now reached eleven. These serve as loci of consultation and special testing, and for long-term treatment of those chronic disorders which are appropriate to each one. They serve not only our general O.P.D. and E.R., but our C.P.C. (q.v.), the Well-Baby Clinics of Western Baltimore, our affiliated hospitals and any practicing physician who wishes their services. For your information, the clinics, whom to call, and their telephone numbers are listed below:

### Allergy

*Shih-Wen Huang, M.D.  
528-6662*

### Behavior

*Stanford B. Friedman, M.D.  
528-6824*

### Cardiology

*Robert Gingell, M.D.  
528-6529*

### Central Evaluation

*Raymond L. Clemmens, M.D.  
528-6950*

### Dental

*Sophia Balis, D.D.S.  
528-6425*

### Endocrine

*Salvatore Raiti, M.D.  
837-2552*

### Exceptional Child

*Ruth Baldwin, M.D.  
528-5300*

### Genetic

*Bernice Sigman, M.D.  
528-6669*

### Hematology and Oncology

*Ruth E. Luddy, M.D.  
528-6567*

### Learning Disabilities

*Murray M. Kappelman, M.D.  
528-6615*

### Metabolic

*Noel K. Maclaren, M.D.  
528-6911*

**Neurology**  
Robert S. Mosser, M.D.  
528-6764

**Renal**  
Edward J. Ruley, M.D.  
528-6911

### **HEMATOLOGY CLINIC**

Ruth Luddy, M.D.

The pediatric hematology specialty clinics are devoted to the care of patients with a variety of hematologic and oncologic problems. Children less than 12 years of age receive care in clinics held on Wednesday and Friday mornings; teenagers 12 through 18 years of age are seen on Tuesday mornings in the adolescent clinic and private hematology and oncology patients are met every Wednesday afternoon. Each clinic is supervised by one pediatric hematologist and is staffed by several pediatric house officers. A specialty clinic social worker is available for patient and family counseling.



Dr. Bonnie Vestal supervising the intravenous administration of a chemotherapeutic agent to a lad in the Hematology-Oncology Clinic.

An effort is made to evaluate and treat such youngsters as outpatients in order to minimize hospital stays and permit patients with chronic or fatal illnesses to function as normally as possible.

The hematology clinics have been a major referral center for patients with hemoglobinopathies and other anemias (non-iron deficiency) detected in the Child Health Clinics of the Baltimore City Health Department. Currently about 90 children and teenagers with sickle cell anemia, Hemoglobin SC disease, and Sickle Thalassemia are receiving care. All members of the immediate family receive definitive testing for the presence of an abnormal hemoglobin. For three years this clinic was supported by the Thomas Wilson Foundation.

At the present time approximately 50 patients with a variety of other red cell disorders, platelet and coagulation problems attend the pediatric

hematology clinics. An additional 35 patients with acute leukemia or solid tumors are currently receiving treatment. These clinics & programs have been made possible by the generous gifts from the Edith Rosen Strauss Foundation and the Dorothy Friedman Caplan Guild.

### **CARDIOLOGY CLINIC**

Robert Gingell, M.D.

The subspecialty of Pediatric Cardiology offers several clinics for evaluation of patients with congenital or acquired cardiac disease. This clinic has been under the supervision of Dr. Sidney Scherlis with the able help of Dr. Karl Weaver for many years.

Basically, there are clinics for infants, children and adolescents. However, considerable overlap is allowed to fit the family's requirement for travel and availability. More recently, laboratory studies such as vectorcardiogram, phonocardiogram and echocardiogram are available in addition to ECG and X-ray. Furthermore, catheterization and angiography are available on an elective, semi-urgent and emergency basis, depending on the needs of the patient. Close collaboration exists with the Pediatric Cardiovascular Surgery group to help insure prompt attention to both medical and surgical aspects of overall care as they arise. Regularly scheduled Pediatric Cardiovascular Conferences are designed for presentation of current diagnostic studies with open discussion of the alternatives for management. Practicing physicians and house staff are welcome to attend and participate.

Research activities in cardiology proceed in both the clinical and basic areas. Our clinical studies involve a collaborative study of the influence of maternal hormone therapy on the incidence of congenital heart disease. At the same time, a laboratory study investigating some basic aspects of myocardial metabolism has been established.

The entire staff is continuing to refine both the mechanism and facilities for referral in an effort to better serve the children of Maryland with cardiac disorders.

### **PEDIATRIC NEUROLOGY**

Robert S. Mosser, M.D.

The Pediatric Neurology Clinic meets one-half day each week for referred elective neurological consultations and for long-term observation and treatment of proven and suspected neuromuscular disease. Appointments are made for 9 to 12 patients each week. These patients are usually referred from the pediatric wards and clinics of the

University of Maryland Hospital, but practicing physicians, outside clinics, schools and other hospitals also contribute to the clinic population. The staff is made up of a secretary, nurse, staff physician, neurology resident, and pediatric resident. At times, medical students and neurologists preparing for board examinations attend the clinic, and clinical teaching and experience is a constant secondary function of each session.

Most of the patients are followed for long periods of time since developmental disorders and chronic neurological disease requiring medical support are common in this clinic population. Many are seen only once or twice a year. A relatively small proportion of new patients may be admitted to the hospital for diagnostic tests and observation. Neurological consultations can usually be completed in the clinic by history and examination. Psychophysiological reactions of childhood and adolescence are seen with increasing frequency as a by-product of the adolescent medicine program development of recent years. These children have usually had a neurological consultation requested by a school physician, nurse, psychologist, psychiatrist or teacher.

In the 15 years that the clinic has been held, children with almost every variety of neurological and muscular disease have been seen. The other pediatric outpatient facilities of University Hospital which deal with many of the same problems which used to be seen in neurological pediatrics have made clinic expansion and growth unnecessary for the present.

A monthly clinic in adolescent neurology is now available as a part of the adolescent outpatient program to supplement the children's clinic.

#### **NEPHROLOGY CLINIC**

*Eward J. Ruley, M.D.*

The Pediatric and Adolescent Renal Clinics each meet weekly in the Pediatric Specialty Clinic area. These Clinics were established in 1970 to provide for the evaluation and management of pediatric age patients with renal disease. Such disease in the pediatric age patient poses some special problems. It is during this age that most cases of embryologic maldevelopment and inherited nephropathies will first manifest themselves. In addition, any abnormalities of renal function within patients of this age must always be interpreted in relation to the continually changing developmental aspects of renal physiology. The age, size and metabolic immaturity of pediatric patients limits the use of certain diagnostic techniques and makes medical management somewhat complicated.

These clinics are staffed primarily by housestaff and senior medical students under the supervision of a pediatric nephrologist. In the two years since their formal establishment, the population of patients utilizing these services has increased, due to increased utilization by the people in the immediate area served by the University of Maryland Hospital, as well as to an increased number of referrals from other parts of the City, the State of Maryland and surrounding states.

At present each session is limited to ten to twelve patients so that the most comprehensive care can be rendered and the greatest amount of teaching can be done.

A pediatric diagnostic research laboratory has been funded for the past three years by the Thomas Wilson Foundation. This laboratory provides diagnostic capabilities not otherwise available in the general hospital and, in particular, has set up special tests in the area of complement activation and the immune mechanisms involved in various renal diseases. The same foundation has also supported the establishment of a renal biopsy program for children which has proven to be a valuable diagnostic tool. While this test is only done on an inpatient basis, the prebiopsy studies and post-biopsy follow-up are performed in the clinic.

Attempts are made to forward the results of evaluations to referring doctors and agencies as quickly as possible with most patients being managed jointly by the referring physician and the nephrology clinic.

#### **ALLERGY AND IMMUNOLOGY**

*Shi-Wen Huang, M.D.*

The original Pediatric Allergy Clinic which was founded more than 10 years ago is now expanded into the Pediatric Allergy and Immunology Clinic.

Allergic disorder is one of the most common childhood diseases in this country. A recent survey of school children has shown that bronchial asthma is one of the main reasons for school absenteeism. At the present, we have registered about 450 cases in this Clinic. More than 80% of them belong to the respiratory allergy group which includes bronchial asthma and allergic rhinitis. Atopic dermatitis, food allergy and insect allergy are less common but are important disorders for pediatric ages. The functions of the Allergy-Immunology Clinic are to provide diagnostic work-up, immunotherapy and continuity of care.

Diagnostic tests that we use include skin tests, sweat chloride test, peak flow meter and nasal smear for eosinophils. We are currently screening all the patients for their serum level of IgA and IgE.

Selective IgA deficiency is considered to be one of the most common primary immunodeficiencies with an incidence of about one in 600 to 700. Some of them have sinopulmonary infection with their allergic symptoms. High serum IgE is known to be present in many allergic disorders, and we are currently studying its importance in diagnosis and follow-up of clinical activity of the patients. Another immediate goal of this Clinic is to try to coordinate the efforts of staffs from adolescent Medicine and social workers to provide medical and social assistance to increasing numbers of intrinsic asthma patients of adolescent ages.

Our Allergy-Immunology Clinic also accepts referrals of patients with various immune disorders. These include patients who suffer from frequent or unusual microbial infection and any autoimmune disorders of the pediatric age group, such as systemic lupus erythematosus, juvenile rheumatoid arthritis, dermatomyositis and other poorly defined vasculitis groups. Our clinical immunology laboratory provides the following tests for the evaluation of immunological status:

1. Identification of subpopulation of lymphocytes by different markers,
2. Lymphocyte stimulation tests,
3. Measurements of functional antibodies,
4. Autoantibody screening by immunofluorescent and hemagglutination techniques (anti-DNA antibodies),
5. Radioimmunoassay for serum IgE and
6. Functional assay of phagocytes.

Currently, this allergy Clinic is staffed with two Board Certified Pediatric Allergists and Clinical Immunologists and two experienced nurses. The clinic is open Monday and Wednesday (a.m. and p.m.) every week. On Monday afternoon there is a special clinic for hyposensitization.

All patients are seen in the Pediatric Clinic or by a pediatrician before referral. The clinic is located in the Community Pediatric Center of the University of Maryland on Redwood Street, Baltimore.

## OUTREACH SERVICES

Not content with supplying good health care to the infants and children who are brought to the hospital, the Pediatric Department has assumed a number of responsibilities in areas outside its walls, some adjacent, some geographically remote. Many of these are described in the following pages.

## EXCEPTIONAL CHILD CLINIC

*Ruth W. Baldwin, M.D.*

The Clinic at University of Maryland Hospital was formed in the fall of 1949 with one-half day clinic a month but soon grew to three half-day clinics a month. The present program was developed in 1950 under the auspices of the Children's Bureau through the Department of Health and Mental Hygiene with a grant of \$30,000. The personnel consisted of one physician, a secretary, and a social worker. This gradually grew to an \$81,000 grant with three physicians, one psychologist, and three and one-half secretaries. There were three initial charges:

- 1) to set county clinics for the diagnosis and treatment of children with epilepsy.
- 2) to provide teaching to medical students in the diagnosis and treatment of children with epilepsy.
- 3) to change the public attitude.

In 1962, the name of the clinic was changed from the Seizure Clinic to the Clinic for the Exceptional Child because the patient population was broadened to include those with behavior disorders, learning disorders, mental retardation, and multiple congenital disorders.

The first clinic was held in Salisbury, Maryland to handle the most outlying three counties on the Eastern Shore of Maryland—Wicomico, Worcester, and Somerset. Since there were so few epileptics, it was decided that one-half day clinic every other month would be sufficient. Soon there were three full-day clinics a month. Within ten years, Wicomico County itself had three full-day clinics a month and each of the other counties had one clinic per month. Gradually, clinics were set up in other areas. The last county clinic was formed in 1972 in Harford County. Each county now has one to four clinics a month. Many of the counties having only one are requesting more services.

From July 1, 1973 through April 30, 1974, there were 1701 revisits and 113 new patients seen in the county clinics, 818 revisits and 73 new patients in the clinics at University of Maryland Hospital and 145 revisits at Maryland School for the Blind. This makes a total of 2664 revisits and 186 new patients seen during the ten month period. There are also five adult clinics in the counties now serviced by two neurologists from the Neurology Department of the University of Maryland to continue treatment of our patients who have become twenty-one years of age.

Residents in Pediatrics rotated one day each week for three months through the clinic in the early years. Now electives are possible for two to



*Dr. Ruth Baldwin testing the visual fields of a young girl in her clinic for Exceptional Children.*

three month rotations for senior students and residents. Family Practice residents spend one-half day a week for two months in the clinic.

In the early part of the 1950's, the Eastern Shore Epilepsy Association was formed by interested parents. They were able to buy an electroencephalographic machine for Peninsula General Hospital and pay the salary of the technician for the first year. They now have funds which help pay for tests and medicines for those adults who are financially unable to obtain them.

In 1959, the Chesapeake Association of Epilepsy was formed, quickly followed by similar ones in Washington County and Frederick County.

In 1952, consultation services were arranged to be given twice monthly at Rosewood State Hospital. In 1962, monthly consultative services were started at Henryton State Hospital. In 1952, consultative services were requested by the Department of Motor Vehicles, and the Director of the clinic was appointed to the Medical Advisory Board and for the past ten years has served as Chairman of that Board. In 1959, a parent of a patient started Angel's Haven, and the Director of this Clinic was asked to be a member of the Board of Directors as well as consultant for epileptic patients.

In 1962, the first breakthrough in the causes of Cerebral Macular Degeneration was made with the help of Dr. Samuel Bessman in the Pediatric Research laboratory. Urines from a family of five children were brought from Salisbury and found to have a metabolic error in the amino acids and was reported by us in Science in 1962. This opened a broad search for other metabolic disorders in children with epilepsy.

#### **CENTRAL EVALUATION CLINIC**

*Ray L. Clemmens, M.D.*

The Central Evaluation Clinic is an interdisciplinary diagnostic and evaluation center for children with multiple handicaps or problems of atypical

development. The program is operated under the joint aegis of the Department of Pediatrics of the University of Maryland School of Medicine and the Crippled Children's Division of the Maryland State Department of Health.

The clinic is designed to have all of the professional disciplines and ancillary diagnostic services necessary for the evaluation of a handicapped child in a single, centralized and coordinated outpatient setting. The most common clinical problems seen in this facility include the following: mental retardation, cerebral palsy, communication disorders, learning disabilities, "minimal cerebral dysfunction", and multiple physical handicaps. The population served is from birth to age 21 years.

Residents of the state of Maryland are eligible for this service without charge after approval by the State Department of Health. Referrals are accepted from private physicians, hospital clinics, public health agencies, school authorities and other professional persons or agencies. The clinic operates from 8:45 a.m. to 4:45 p.m., Monday through Friday.

Professional staff includes: pediatricians, psychologists, audiologists, language pathologists, and medical social workers. Consultants are available in all the sub-specialty areas (neurology, psychiatry, genetics, orthopedics, physical medicine, dentistry, special education, etc.). The pediatrician is charged with the responsibility of coordinating all of the findings, interpreting them to the parents, preparing a comprehensive summary of the complete evaluation and formulating a set of optimal recommendations for management. Approximately 250 new children are seen for evaluation each year. The average time for this process is usually between six and eight weeks. The clinic also offers follow-up (re-evaluation) services, as required, for the approximately 4,000 children studied in the center since its inception in 1958.

The goals of the Central Evaluation Clinic for Children are:

1. To provide accurate and comprehensive diagnostic assessment of handicapped and atypical children.
2. To provide meaningful interpretation of the findings to the parents, supportive counseling as appropriate, and recommendations for optimal habilitation and management.
3. To provide a program for the teaching of medical students, house officers and other professional persons wherein the interdisciplinary approach to the diagnosis and

management of handicapped and atypical children can be demonstrated.

4. To study and help elucidate the various components of the wide spectrum of childhood atypicality including epidemiology, diagnostic considerations, natural history, prevention and treatment.
5. To document the need for various facilities for handicapped children (including special education, speech therapy, etc.) in the community and to encourage the establishment of such programs where they are lacking.
6. To promote improved communication and interdisciplinary cooperation among the several disciplines concerned with handicapped children, in particular pediatrics, psychiatry, psychology, education and public health.
7. To help define the complementary roles of these several disciplines in regard to the optimal utilization of skills and techniques as they pertain to the needs of handicapped and atypical children.
8. To provide a program of on-going self-evaluation.

Beginning in 1975, it is anticipated that the clinic will be incorporated into, and become the ambulatory arm of The Mental Retardation-Mental Health facility now being constructed by the Maryland State Department of Health and Mental Hygiene.

#### **THE COMMUNITY PEDIATRIC CENTER (C.P.C.)**

*George A. Lentz, Jr., M.D.*

*Oscar C. Stine, M.D., D.P.H.*

*Ray Hepner, M.D. and*

*Prassanna Nair, M.D.*

The Department of Pediatrics has been involved since 1967 in the unique experience of the delivery of comprehensive health care to children and youth. Traditionally, health care for the poor in the inner city saw preventive care being delivered in Well-Baby Clinics, acute care in hospital emergency rooms, and secondary care in various clinics. As a result, the families derived care from multiple sites and multiple suppliers. Originating as a demonstration service project grant, Title V of the Social Security Act of 1965 created children and youth projects which were to deliver comprehensive care for a specified population of disadvantaged children and youth. Our C.P.C., one of five such projects in Baltimore, serves a target area comprising nine census tracts, housing 37,000 persons, 13,000 of whom are children and

youth under the age of 19. This population is one characterized by low socio-economic and high health-need indices.

The C.P.C. saw its first patient in its current quarters on September 7, 1967. At the present time, it is operating as a five-day, 8 a.m. to 5 p.m. Clinic, with backup support on evenings and weekends by the University's Pediatric Outpatient Department.

The care plan is to make possible comprehensive health services for the children offering a full spectrum of care, including case finding, preventive health services, diagnosis, treatment, correction of defects, and after care, both medical and dental. These programs are to focus on health promotion, utilizing a multidisciplinary approach meeting the medical, physical, dental, social, and emotional needs of the low income population. Further emphasis is placed on making the care continuous and personalized and coordinated with other child health development services. Regular planned encounters are scheduled in which the children and youth receive the appropriate immunizations, and a battery of health screening examinations that vary according to the age of the child. These include vision, nutritional, medical, and dental examinations. In addition, height, weight, head circumference, and skin fold measurements are plotted to monitor growth. The Denver Developmental Screening Test is performed regularly in pre-school children and all children receive a periodic hematological survey for anemia.

Long-term follow-up is carried out by the staff and by specialty consultants from the Department of Pediatrics and other clinical departments at the University in planned sessions. Emphasis here is bringing the consultants to the primary care clinic and avoiding as many referrals as possible to promote the "one-door" comprehensive picture of the program.

Full dental services under the direction of Dr. Sophia Balis, ranging from regularly planned periodic dental screening to the treatment of orthodontic problems is carried out. Nutritional, psychological and social work services are available on referral from the medical and nursing staff of the center.

Since the beginning of the program, the primary care person has been the Public Health Nurse. Each of the nine census tracts is assigned to one Public Health Nurse, who is the advocate for that segment of the population, while each staff physician is assigned a pair of census tracts. These, with a psychologist, social worker, nutritionist, and appropriate medical specialists constitute a nurse-doctor team intimately aware of the indi-

vidual needs of their children. This method has been highly successful and has allowed the clinic to fulfill its goal of continuity.

As the program developed over the years, the staff determined areas of special need. As a result, special projects were sought that would provide service to meet those needs or to develop methods of health care delivery that could be implemented by others. As one example, 16% of our population were identified as having delayed growth and intellectual development, and a public school service project, described later, was established to meet this crying need. A Family Planning Project using teenagers as teachers, was carried out and evaluated. The Teenage Pregnancy and Gynecology Clinics became active specialty service areas, while nutrition and dentistry were subjected to intensive screening and made the subject of in-depth treatment and community education.

In this atmosphere of high quality care, exemplified by continuity and comprehensiveness, an active training program has been carried out. Students from the School of Medicine and of Nursing, Dentistry and Social Work are active participants in health care delivery, in a learning-serving role. Various summer fellows over the years have carried out multiple, short-term study projects. Students from the Neighborhood Youth Corps Program have been employed at the C.P.C. as well as in other areas of the Department of Pediatrics in career-training programs.

Since this is a demonstration project, evaluation was and is a strong component of the Program. The Center participates, along with the other 70 Children and Youth Projects across the country, in a very complex detailed reporting system. The following chart gives some idea of the actual number of visits in the various areas and by age group.

### VISITS

JAN-DEC	MEDICAL	DENTAL	TOTAL
'71	17,848	7,580	25,428
'72	21,661	9,230	30,895

AGE	1970 CENSUS	606A REGISTRATION	NO. PERSONS VISITING 1971-1972	NO. ACTUAL VISITS MADE	
				1971-1972	1971-1972
0-4	3053	2756	2260	10,482	12,383
5-12	5721	5473	2571	2623	12,383
13-18	3930	3216	630	1079	2,623
TOTAL	12,704	11,445	5461	6348	30,895

Outcome measures are harder to quantify. The Center has lowered hospital admission rates and markedly reduced visits to the Emergency Room during the evening and weekend hours. The combined program of early dental evaluation, treatment and dental education in the pre-school child has reduced the incidence of dental pathology in the elementary school population to such a level that the staff can now direct its attention to the older teenage population that could not be served in the past because of high case and work load. Recently, Dr. Leon Gordis reported marked reduction in the incidence of rheumatic fever in the regions served by the Children and Youth Programs. This is attributed to the comprehensiveness of the total care program and is an excellent outcome measure. A survey of first-grade children in our area in 1966 determined that the level of iron deficiency anemia was about 25%. This focused public attention upon this problem and led directly to a federally funded Iron Fortified Milk Program under the Model Cities Agencies. By constant monitoring of the hematological and nutritional health of the childhood population served by the C.P.C. along with major educational programs and the Iron Fortified Milk Program, the incidence of anemia, again among first graders, has fallen to 7.6%. Recently, in the screening program carried out among Medicare-eligible first graders, less than 2% had hematocrits of less than 33.0.

The programs have heightened community awareness of health matters, have provided a medical resource to a large population of children who previously received uncoordinated health care, have lowered hospital admissions significantly, have developed and trained new categories of community workers, and have developed models for delivery of comprehensive health care services. In spite of all its efforts and accomplishments, the area remains a level of great health need, since one of the major determinants of poor health is the poverty which still exists.

The University C.P.C. along with the other Children and Youth Projects in Baltimore which are delivering comprehensive care to more than 35,000 children and youth, have the potential for conversion to health maintenance organizations (H.M.O.'s) providing health care for both children and adults. One of the centers has already moved in this direction. The Department of Pediatrics is in discussion and planning with the Departments of Medicine, Preventive Medicine, Social Medicine and Family Practice, towards this goal.

The Community Pediatric Center has been and is a unique experience in service, education, and research.

## PUBLIC SCHOOLS

Murray Kappelman, M.D.

During the 1973-1974 academic year, the Pediatric Department Behavior and Learning Problems Team, funded through a grant from the federal and state government and receiving additional support from the Baltimore City Public Schools and the Baltimore City Health Department and under the direction of Dr. Murray Kappelman with Dr. Polly Roberts and Dr. Hilary Spence as Pediatric School Health Fellows, operated a multidisciplinary team operation in all 18 elementary schools in Region 8 which surrounds the University of Maryland Hospital. The program was both innovative and unique in that school health was redefined as primarily that aspect of Pediatrics which was responsible for the educational and emotional well-being of children of school age. The acute intermittent primary care problems were triaged out by the school nurse acting as a Pediatric associate with the school physician functioning as consultant. Clinics, Comprehensive Pediatric Centers, and private physicians acted as the primary health care deliverers for those school children who had acute illnesses. However, all those children demonstrating problems related to their school learning and school adaptation were referred through the teacher and principal to the multidisciplinary School Health Team which functioned one-half day every two weeks within each elementary school. Eighteen schools were serviced by this multidisciplinary team which consisted of the pediatric behaviorist as supervisor, pediatric school health fellow, child psychiatrist consultant, social worker, psychologist, speech and hearing clinician, school nurse, diagnostic and prescriptive teacher, and diagnostic and prescriptive teacher intern.

During 1972-1973, the first year of this expanded operation, ten schools were involved. The Team saw 153 children that year for diagnosis, evaluation, and short-term remediation or referral to appropriate resources. During this second year of operation, it is estimated that between 250 and 350 children will be seen either as new patients or follow-up patients by this special school health multidisciplinary team. The Baltimore City Public School System has accepted this plan of operation as a model which they hope to incorporate throughout the City of Baltimore as a multidisciplinary team approach to childhood learning and behavior problems utilizing personnel already existent in the school and training special personnel such as school health physicians and school nurses to handle the specific emotional and educational problems of the elementary school.

This project demonstrates the Department's outreach into the educational community and utilization of the interdisciplinary concept of maximal provision of optimal child care.

## VARIOUS OTHER OUTREACH PROGRAMS

Misbah Khan, M.D.M.P.H.

The present day indices of health when considered under major subdivisions of physical health, mental health and social health make obvious the obsolete nature of traditional approaches to provision of health services. Whereas the clinics are suitable for the physical care of young children, providing preventive care and acute care services, they cannot meet fully the present-day problems of mental and social health of children. Health problems such as the increasing number of pregnancies in young teenagers, rising venereal disease rates, growing prematurity rates, juvenile delinquency and crime require specific educational, psychological and counselling services which the health clinics of the future must supply.

### I. *Public Schools 1 and 1A for Pregnant Teenagers.*

Continuing health education is an integral part of the school curriculum at both the Junior High and Senior High Schools. The enrollment at both is approximately 1,200 students a year. The figure represents one-third of the total number of pregnant teenagers in Baltimore City. The educational program is directed toward making the teenage pregnant girl feel adequate in her ability to cope with life as it has evolved for her. Relevant information pertaining to health care for both mother and infant is made the focus of discussions at seminars held weekly at both schools. Topics include pregnancy, labor and delivery, nutrition, careers, drugs, contraception, long-term planning for self and baby. The resident acquires an understanding of the complex needs of pregnant teenagers and their infants and learns to simplify health information relevant to students of this age.

An important part of this program is the "Hospital Tour" (for eight to ten students at a time) of the Obstetrical and Nursery services, both at University Hospital as well as at the Maryland General Hospital. This is conducted jointly by Pediatric residents and nursing staff.

### II. *Baltimore City Child Health Clinics.*

Pediatric residents staff the Child Health Clinics of the Western Health District of Baltimore City. This arrangement with the City Health Department enables:

- 1) The traditional Well Baby Clinics to serve as primary care centers for children where both pre-

ventive and curative services are provided. Approximately 8,000 children are given service at our Child Health Clinics every year.

2) The physician-in-training gains valuable experience in community Pediatrics, diagnosing and treating common pediatric problems, observing growth and development in children over a period of time, counselling mothers regarding nutrition, child rearing practices, etc. The most important aspect of this experience is the close working relationship with the Public Health Nursing Service.

### *III. Maryland School for the Blind.*

This is a residential institution for the education of approximately 450 blind children from kindergarten through high school grades. Medical care is provided by our pediatric residents under the direction of a faculty member of the Department of Pediatrics.

The health center at the school is staffed by four full-time nurses and a full component of health personnel. Clinics are held twice a week at the health center.

For the student, there is an opportunity to observe facilities for the very special needs of handicapped children, the educational and vocational programs of the school, as well as the opportunity to participate in the medical, dental and nursing services which they require.

### *IV. State Health Department Rotation.*

A joint program with the State Health Department provides an experience in health administration to the trainee physician. Goals are to familiarize the trainee with the organization of health services administration by observing and participating with the professionals in their day-to-day work.

## **ROSEWOOD HOSPITAL CENTER**

*Barbara W. Hudson, M.D.*

In July, 1973, Dr. Marvin Cornblath, Chairman of the Department of Pediatrics, approached me with the suggestion that I accept the position of Medical Director at Rosewood Hospital Center. This union of the Department of Pediatrics and Rosewood would give an opportunity to further expand the health care system that had been begun at the School for the Blind approximately three years ago.

Rosewood Hospital Center is the residential setting for the mentally retarded in the State of Maryland. There are 2,000 residents ranging in age from a few weeks to the 80's. Unfortunately, over the years, there has been much adverse publicity about the "inhuman conditions" at Rosewood and virtually no notice of the many positive changes that have occurred in the last year.

A new era at Rosewood began with the arrival of Dr. Marvin M. Malcotti, a psychologist who has had wide experience in the administration of residential facilities for the retarded and who sets very high standards for his staff. He is keenly aware of the importance of a strong medical staff and has provided continual support to the Medical Director in the setting up of a new Health Care System at Rosewood.

The model for the delivery of Health Care at Rosewood is that of the Southbury Training School at Southbury, Connecticut under the direction of Dr. Herman Yannett. The concept is based on the following principle: the resident is basically well and the supervision of his life in the cottage should be under the direction of the Cottage Administrator and not the physician. Health Care should be provided in the Out-patient Department by a staff of physicians with supportive services nearby.

It is this system that has been in effect at Rosewood since July 1st, 1973. The residents are seen in their cottages each day by a Nurse Practitioner. These are a group of employees (R.N.'s, L.P.N.'s and H.A.'s) who have been trained by the Medical Director to act as physician's helpers or substitute parents in the cottages. The R.N.P.'s (Rosewood Nurse Practitioners) treat according to Standing Orders issued by the Medical Director. If they feel a resident needs to see a physician he is sent to the Clinic on a bus that makes rounds through the grounds.

In the Clinic, the resident is seen by one of the staff physicians, treated and then returned to his cottage. If necessary, he can be admitted to the Intensive Care Unit in the Medical Center at Rosewood or one of the other wards under the supervision of the Chief of the Inpatient Service who is a board-certified pediatrician.

Special medical problems are seen by consultants in all areas who visit Rosewood on a regular basis. Teaching rounds are conducted twice a week as well as conferences. Each physician is expected to spend half a day away from Rosewood attending clinics or rounds at the University of Maryland.

There are many positive aspects to this type of Health Care. The resident is seen frequently by a group of employees who know him well and who are alert for signs of illness. The physicians are able to concentrate on practicing good medicine in optimal surroundings. The nurse practitioners have been given additional responsibilities which add to their efficiency and the residents profit by being seen more frequently.

Plans are being made to offer an experience at

Rosewood for our Pediatric Residents. A tremendous insight into mental retardation and institutional living can be gained and should be part of every doctor's training.

## **THE APPALACHIAN PEDIATRIC RESIDENCY PROGRAM**

*Robert D. Brodell, M.D.*

*Misbah Khan, M.D., M.P.H.*

*Marvin Cornblath, M.D.*

In 1971, after considering the health resources and identifying manpower needs in Allegany and Garrett Counties, the Appalachian Commission along with the Health Planning Council of Western Maryland, requested Dr. Marvin Cornblath to assist in the planning and delivery of pediatric services in the two counties.

Planning began in 1971 and entailed meetings first with the Health Planning Council. Once the Program had been approved by the Health Planning Council, Dr. Robert Brodell, partner in the Children's Medical Group, Cumberland, Maryland, and Clinical Assistant Professor in Pediatrics at the University of Maryland; Dr. Marvin Cornblath; Dr. Karl Weaver, Professor of Pediatrics, University of Maryland; and Dr. Mishbah Khan, Assistant Professor of Pediatrics, University of Maryland, reviewed existing resources and planned a course of action to be undertaken by the University, plus those private and public sectors of health personnel to be involved in a joint effort.

The planning phase of the Program took into consideration the geography, the distances, the population, existing health services, personnel, and the roles of the public health nurses and physicians who were involved in the delivery of health care.

The Children's Medical Group (CMG), composed of Dr. Brodell, Dr. Robert Dawson and Dr. Gary Fleming, is the supervisory agent for the Pediatric Residency Program. The Program is directed by Drs. Cornblath and Weaver. Dr. Khan acts as faculty liaison, visiting the project monthly.

Pediatric residents who choose to rotate through the Pediatric Residency Program receive eight weeks of clinical field experience in Allegany and Garrett Counties, working with county health officers, public health nurses, paramedical personnel and social workers. Two days each week the resident sees his own patients in the CMG Center in Cumberland, and two days each week visits pediatric clinics in Garrett County. The remaining day is used electively for specialty clinics in the Allegany County Health Department.

The objectives of the program are: 1. Service—to provide service to children who previously had not received health care or only episodic care. 2. Training—to make this Program an integral part of the resident's training so as to give the trainee a first-hand exposure to: (a) Medical practice in rural areas; (b) Private practice, a model for the efficient delivery of health care providing an opportunity for the resident to become aware of administrative as well as financial aspects of group practice. 3. Future—(a) To generate an interest among young physicians in pediatric practice in rural areas. (b) To support and strengthen existing services and ultimately to enable independent functioning of staff and clinic. (c) To continue to share university concepts and teachings with rural areas.

Pediatric residents from the University of Maryland School of Medicine have made remarkable contributions to Western Maryland—and not only in the number of patients seen. The contributions center on services to children but importantly, too, they demonstrate the changing concept of medical education and physical training. Part of this experience is located at the clinics in Oakland and Kitzmiller, Garrett County. The clinic in Oakland is the County Health Department located in Garrett Memorial Hospital. This location easily allows pediatric residents to be available in consultative capacities to a medical community which has had no fulltime pediatrician. Kitzmiller, Maryland, is located directly across the river from West Virginia. It is currently a medical outpost—20 miles of mountain roads from the nearest fulltime M.D. and hospital. The facility is a former physician's office consisting of two examining rooms, waiting room, nurses area and bathroom. It is planned to completely remodel this office at the first opportunity, but in the meantime the resident has learned to improvise in the "trenches" of frontline medicine.

Teaching and supervision of the resident's activities in both counties is provided by the CMG. In effect, a true preceptorship is demonstrated, whereby the trainee-physician is able to establish an independent identity along with a relationship with senior colleagues encompassing professional, educational, social and ethical issues and attitudes.

This Program was the first project from the Health Planning Council of Western Maryland funded by the Appalachian Regional Commission (A.R.C.). During the first two years of a grant term, the A.R.C. funding is 100%. For the following three years, 25% of the grant must come from other sources. Other sources may include "in

kind" and generated income as well as other non-ARC grants.

In 1973, the addition of a pediatric nurse practitioner has allowed the Program to become involved with other federally and state supported programs which need medical support.

It is difficult to measure the effectiveness of a program such as this. It is easy to present the numbers of patients seen, the locale where the resident spends his time, and the types of problems with which he becomes involved. Another measure of effectiveness is resident and patient response to the Program; but there is no measure to the human interaction and the immeasurable rewards of personal satisfactions in the lasting friendships formed.

## AFFILIATED HOSPITALS

*Wilson Grubb, M.D.; Ernie Maher, M.D.;  
William Quivers, M.D.; Stewart Walker, M.D.*

Over the course of the past years a process of regionalization has developed with the University Pediatric Department becoming the nexus of a number of community hospitals. It serves them first as their locus of secondary care, that is, for sophisticated consultation in a large variety of subspecialties. Among these are cardiology, hematology, oncology, neurology, nephrology, allergy, seizure disorders, psychologic evaluation and child psychiatry, inter alia. The University Pediatric Department serves as the site for continuous comprehensive care for many of the chronically sick infants and children in the city and counties, a continuity which cannot always be supplied by community hospitals.

In addition, our department accepts, with pleasure, referrals for Inpatient Care of selected patients. These are funneled in for cardiac catheterization and renal biopsy, for treatment of leukemia and neoplasms, for severe respiratory distress and for the correction of major congenital defects.

The forms which these interdepartmental associations or affiliations have assumed differ markedly in kind. At one end of the spectrum stands the Union Memorial Hospital. Its pediatric service—Newborns, Inpatients and Outpatients—has become one of the regular rotations of our own house staff. There are always four University pediatric residents at the Union Memorial Hospital. Ward Rounds are made at least once a week by our Chief of Pediatrics. Patients and house staff benefit from continuing supervision by both full-time faculty and by fine private practitioners who serve as attendings on the Wards. All of this is coordinated and supervised by Dr. Wilson Grubb, the Chief of Pediatrics. Pediatric con-

sultants from the University Hospital respond to consultation requests with alacrity. The result is that pediatric patients at the Union Memorial Hospital are assured the best in diagnosis and treatment while our residents gain experience in managing disease of somewhat different nature and in a stratum of society different from that to which they are for the most part exposed for the rest of the year.

The affiliation with the pediatric department of the South Baltimore General Hospital is similar in most respects, but dissimilar in others. Here the residents are selected by Drs. Ernie Maher and Stuart Irwin, ex-students and ex-residents of ours, who have assumed the major burden of patient supervision and resident training there. Each of their residents spends six months of each year with us. In this way they earn credits toward specialty board approval. Our consultants are all available and are freely utilized by them. A significant number of their difficult problem children are transferred to our inpatient service. The arrangement with the Provident Hospital is similar, with residents rotating to the University of Maryland Hospital. Their chief of Pediatrics, Dr. William Quivers, is a valuable member of our teaching faculty.

The affiliation of Mercy Hospital with the University of Maryland has continued since the amalgamation of the College of Physicians and Surgeons and the University's School of Medicine. With the appointment of Dr. Stewart Walker as Chief of Pediatrics, aided by a full-time staff at Mercy, student teaching has been a primary responsibility of that staff. Their residency training program is fully approved and independent of our program. Their residents can select elective experiences at University of Maryland Hospital. The affiliation between the Department of Pediatrics at Mercy and at the University provides distinct advantages to each.

We have established a cordial relationship with the Baltimore City Hospital Pediatric Department, headed by the outstanding Dr. Harold Harrison. A number of our students received their basic education in junior pediatrics and elective experiences as seniors at City Hospital. Faculty members from City make teaching rounds here.

We welcome all hospitals throughout the state to utilize our services for both patient care and post-graduate education.

One cannot doubt that such collaboration between our pediatric service and those of adjacent and distant hospitals works both to their advantage and to ours, and, more importantly, to the excellence of the health care we can offer conjointly to infants and children of Maryland.

## TEACHING

Teaching occupies a position equally as important as patient care when the Medical School-Hospital complex is considered as a unit. This becomes doubly true when we remember that as of now internships no longer exist, which means that our graduates must be prepared to assume the duties of residents immediately after graduation. Pediatric education soon will entail a careful introduction to the subject in the first year, amplification in step with the student's increasing exposure to pathology and physiology in the second year, sound clinical experience in the third year, topped off with intensive clinical clerkship and primary care training in the fourth. Teaching them continues throughout the residency years, and ideally goes on in appropriate ways throughout all one's postdoctoral years.

### STUDENT TEACHING

*Murray Kappelman, M.D.*

Currently, the Department of Pediatrics first contacts the medical student during the sophomore year when the student is assigned for two sessions to learn the special qualities related to pediatric physical diagnosis. During the third year of medical school, the Junior medical student is assigned to Pediatrics for a six-week period of time. Three teaching institutions in the City of Baltimore are utilized as sites of instruction for Junior clinical Pediatrics. Each of these hospitals has essentially the same basic core program though the methods of teaching and time allocations may vary depending upon the specific inner administrative and clinical organization of the particular departments.

During their Junior year, the students receive instruction in the care of the newborn, in-patient child care and ambulatory Pediatric care. They are requested to spend nights in the Emergency Room as well as on the wards so that they may experience acute primary care of an emergency nature as well as the total process of ward admissions. In each of the programs, the student has the benefit of tutorial programs in which small group teaching is led by one of the faculty members and a minimum of 12 general topics are discussed utilizing the seminar-case study form of instruction. Core lectures as well as core conferences are requisite teaching devices during the junior year to stimulate reading and add additional basic pediatric information. At the University of Maryland Hospital, there is a teaching resident specifically allocated to teach the students at the bedside and cover subjects and material which are ordinarily not covered by the other aspects of the course.

During the senior year, the student has the opportunity of many elective experiences in Pediatrics including preceptorships in the offices of practicing pediatricians, ward experiences as a student intern, ambulatory experiences at the Comprehensive Pediatric Center or in the pediatric ambulatory area, as well as experiences in Pediatric Cardiology, renology, and other subspecialties.

In October of 1973, the Department of Pediatrics initiated a Pediatric Tracking Program in which ten freshmen were enrolled and given the opportunity to begin an intensive exposure to all aspects of the pediatric specialty over a four-year period. During the freshman year which is now underway, the freshman tracking students are experiencing a one-month introduction to pediatric physical diagnosis, a three-month experience in the pediatric research laboratory under the direction of Dr. Tyson Tildon and other members of his Department, and clinical experiences which range from well baby clinic experience with Dr. Polly Roberts, pediatric psychology experience with Dr. Thomas Kenny and pediatric ward physical diagnosis experience with Dr. Robert Gingell. The program is under the leadership of Dr. Polly Roberts. In the Sophomore year the students will continue on the pediatric track one afternoon a week. Experiences will be available in one or more of the following areas: the hospital wards, the newborn nursery, Community Pediatric Center, Prenatal Obstetrics Clinic, and School 1 and 1A for the pregnant teenager.

In general, the hope of the Pediatric Department is ultimately to create from Year 1 through Year IV a continuum of Pediatric education which begins with growth and development, moves through physical diagnosis into an appreciation of the basic fundamentals of the child in health and disease, and ultimately develops correlative reasoning and management acumen sufficient for the student to fully appreciate the child and the adolescent, when encountered in any specialty which the student selects as a medical career.

### RESIDENT TEACHING

*Karl Weaver, M.D.*

The goal of the residency teaching program is to provide an in-depth basic experience in pediatrics and a wide variety of patient care, community service and/or research related experiences that are best suited to the individual resident's future plans. The department also supports an affiliated residency program in several community hospitals. Over the years, many changes have taken place. The number of residents in the program

and the number of learning opportunities available have increased significantly. The resident staff, numbering 9 in 1968, will include thirty residents for the year 1974-75. The number of applications for positions on the house staff has risen in a similar manner.

The current program evolved from suggestions both by house staff and faculty.

Our effort is to make the training program meet the needs of the individual physician as well as to provide the best possible services for children.

The training period encompasses the guidelines of the American Board of Pediatrics, the proficiency of the individual and the needs of the service. The program is divided appropriately between a basic core of clinical pediatrics followed by a challenging period of supervisory and elective experiences. Throughout the entire program, the resident furthers his own education by participating directly in the education of medical students and his fellow residents.

#### **POST-DOCTORAL TEACHING**

*Karl Weaver, M.D.; Ray Clemmens, M.D.; and William Seabold, M.D.*

Ever since its establishment, the Department of Pediatrics has been strongly committed to providing continuing education. Shortly after becoming the Chairman of Pediatrics, Dr. J. Edmund Bradley established an annual continuing education program—Pediatric Day—which is now called the Bradley Pediatric Seminar in his honor. This is a program at which outstanding authorities in various aspects of pediatrics make a formal presentation and then provide a period for questions from the audience. The topics are selected by a committee of practicing pediatricians. This program has continued to be an annual occasion on a Sunday in April or May, and this year marked its 23rd consecutive year.

As the Department has grown, so has its involvement in continuing education. This growth reflects the educational philosophy of the present Chairman, Dr. Marvin Cornblath—that a vital responsibility of the Department is to provide educational experiences of high quality to the practicing community as well as to the research community.

During the year, the Department presents a number of varied conferences, programs, seminars, and topic-oriented day-long presentations. Regular dinner meetings with a guest speaker have attracted as many as 100 participants. These are held 4 times a year. For the past several years there have been annual programs dealing with adolescent pediatrics as well as with the child with

school related problems, including reading disabilities. These have been well attended by other professions including teachers, counselors, social workers, and persons in special education. In addition, 3 to 4 outstanding pediatricians, psychologists and other health professionals have spent 2 to 3 days as visiting professors on our campus.

The inimitable, delightful, charming and wonderful Dr. Cicely Williams continues to serve as our visiting professor for 4 to 6 weeks every fall.

The involvement of the Department in continuing education is perhaps best exemplified by the fact that in May of this year the Department organized and presented a three-day program "Management of Problems in Behavioral Pediatrics, Learning Disabilities, and Chronic Impairments" in cooperation with and co-sponsored by the American Academy of Pediatrics. Physicians from around the world attended this meeting.

The Department is making every effort to respond to the requirement by the State Board of Medical Examiners for participation in continuing education by each individual physician. In that regard, the Department is circulating to the medical community a listing of its regularly scheduled rounds, conferences, and seminars, indicating their theme, the time and place they are held, as well as developing specific topic-oriented all day symposia and programs.

The Department would be pleased to have suggestions from the medical community as to the types of programs which would best suit the needs of the practicing pediatrician as well as any specific topics which are of interest.

#### **RESEARCH—**

##### **A TOOL FOR TEACHING AND SERVICE**

*J. Tyson Tildon, Ph.D.  
Pinar Ozan, M.D.*

One aspect of the research phenomenon that is often overlooked in today's academic forum is the element of people. If you ask any faculty member or scientist at a university medical school what is the most important factor in research today, his answer would vary from the ability to get grant support to the variety of technical difficulties that he faces on a day to day basis. Only on a very few occasions would the answer be people. All too often we think of the ideas and concepts in science as the *raison d'être* for research efforts. The mystique of research is not the communicated ideas but the people who develop and participate in these programs.

The most important contribution of the research efforts in modern medicine has not been

the striking advance in intensive care. It has not been the series of biochemical revelations related to disease processes nor has it been the designs of newer techniques for open heart surgery or organ transplants.



*Dr. Tyson Tildon is doing a spectrophotometric analysis in one of the highly productive laboratories in the Division of Pediatric Research.*

The most important contribution of research has been the attitudinal change that grows out of the continuing desire to answer new questions. The ability to answer questions is a prerequisite for the discipline of medicine. Each patient is a challenge to the intellectual ability of the physician to unravel a new mystery. The best technique that the medical school has for developing this attitudinal skill is giving students an opportunity to participate in research projects. Research requires an ever-evolving creative effort to design experimental conditions that will yield interpretable data. The training of doctors and nurses is founded upon this questioning process. Research efforts in the University of Maryland extend from the biochemical laboratory to care in a rural community. In each setting, in the private practitioner's office and in the sophisticated laboratory, there is a continuing effort to answer new questions.

The Department of Pediatrics has a variety of research projects which are intergrated with the service and teaching programs in Pediatrics. Included among the programs in the Division of Pediatrics Research are studies initiated by members of our house staff. Several house officers have elected to spend as much as six months of their total training period carrying out experimental procedures at the lab bench, and many of these studies have resulted in published articles. Some of the research projects include studies of regional differences in the substrate utilization by the myocardium, and the identification of immunological agents in renal disease. Studies of glycerol metabolism in the brain and studies of infectious diseases in the out-patient setting are

representative of the more than twelve combined clinical and basic investigational efforts in which faculty members work closely with the developing physician.

Efforts are also made to integrate fellowships and student participation into our research program. During the coming year, twelve students will participate as active members of the research team doing basic laboratory studies in the department. Although each of these students will be gaining facilities with specialized techniques such as the isolation and purification of enzymes using electrophoretic and chromatographic techniques, the major emphasis of this experience is to give these students a stronger foundation in developing their ability to answer questions.

Research is continually threaded throughout the cloth of teaching and services in the Department. One of the largest efforts in our Department involves the attempt to determine the deleterious factors associated with teenage pregnancy. One series of questions has given rise to the development of new techniques including biochemical and morphological analysis of the hair root and shaft for evidence of marginal malnutrition. Another collaborative study has been an attempt to define those factors that contribute to sudden infant death. This study attempts to relate the factors of sleep and apnea to sudden infant death.

The research programs consist of several interdisciplinary studies including an investigation of autoimmunity as a cause for juvenile diabetes. In this study, several investigators are attempting to determine if circulating antibodies and sensitized lymphocytes are present in the peripheral blood of patients with juvenile diabetes. In another, the role of renal tubular antigens in human renal disease is being investigated. This project involves the isolation and characterization of renal antigens and the development of monospecific renal tubular antibodies to these antigens. Several groups are investigating the effects of a pituitary tumor on immunocompetence and hormones in relation to malignancy and tissue growth. The use of tumorbearing rats provides the laboratory with a model animal for studies in a variety of disciplines. Other studies in this laboratory include an examination of muscle metabolism in collaboration with the Department of Neurology.

The major efforts of the Department have concentrated on studies of metabolism and developmental biochemistry. Several major breakthroughs include the establishment of a model system for the production of alanine by skeletal muscle and the identification of two new disease conditions. Both of these conditions have been

reported at national meetings. On disease, GM<sub>3</sub> gangliosidosis, is the first description of an inborn error in the synthetic pathway of ganglioside metabolism. The second disease condition, which is associated with glycerol intolerance in a 3 year old infant, has led to an intensive study of glycerol metabolism by the brain. The contribution of the research program has received international recognition. The evidence for this conclusion can be derived from the continual invitations to make presentations in other countries. During the present academic year, presentations will have been made in Israel, Belgium, the Netherlands, Switzerland, Canada and Argentina.

In order to integrate these continuing advances in research into the programs in this Department, presentations are made at Weekly Research Conferences. In addition, research discussions are also offered at Grand Rounds. This has been a very successful mechanism for integrating new ideas and concepts into the ever-advancing clinical and therapeutic routines that are utilized within the Hospital.

The success of these research efforts depends upon people. All of the members of the division of Pediatric Research make contributions, not only to the research programs, but also to service and teaching efforts of this Department. This integration of people throughout the spectrum of the health sciences remains the major role of the Department, and only through the continuing efforts of people can this goal be realized.

## THE SUPPORTIVE SERVICES

Pediatricians are thoroughly aware of their dependence upon nurses and social workers who, working with them as a team, make possible the delivery of sound comprehensive health care to their patients and their families. Within the hospital setting those who carry out the Child Life Program merit equal recognition. Their representatives now tell their stories briefly.

### PEDIATRIC NURSING

Katie Windham, R.N.

June Sheri, R.N.

Marilyn Aten -M.S.

Pediatric nurses are integral members of the interdisciplinary health team. Progressive changes have been effected in the Department of Maternal and Child Nursing during the past four years which are aimed at improving the quality of care for children and parents. There is now a decentralization of the administrative structure of the Department of Nursing, resulting in the placement of responsibility and decision making re-

garding patients within each clinical unit. Thus, the nurses closest to the patients are making the decisions.

The professional pediatric nurse serves as a coordinator of health care, patient advocate, teacher of patients and parents, and frequently, as a primary deliverer of health care. Through the expansion of roles within the nursing profession, there are now clinicians, clinical specialists, and nurse practitioners being utilized to provide a higher quality of nursing care than ever before. The nurse practitioner, functioning with the physician, is able to deliver primary care to patients and be directly involved in the planning of health care.

The nurse within the University setting is also becoming more involved with the community. A unique member of the health care team is the public health nurse assigned to the Pediatric Department. She serves as a coordinator, consultant, and educator to members of the interdisciplinary group. Her efforts are directed at improving both inpatient and Community care. A psychiatric nurse liaison is also available for consultation or conferences regarding patient care.

Collaboration among the health care professionals is furthered by a departmental nursing liaison committee. Here, representatives of the nursing, medical, Child Life, and administrative groups meet to assess present functioning of care for families and to plan for the future.

### SOCIAL WORK

Margaret E. Hayes, A.C.S.W.

Harris Chaiklin, Ph.D.

Our complex society with its multiple agencies, services, and demands requires an expansion of the health team. An important addition has been the social worker who serves many needs. In addition to being a patient advocate, the social worker helps in the adjustments necessary when a catastrophic illness or traumatic injury occurs and produces a major social and emotional disruption for the family.

If the patient is a child, these problems are usually exacerbated. Some problems that require the help of the entire social service department include child abuse, chronic illness, emotional stresses dealing with death or fear of death, changes in body image as well as concern over separation and long hospitalization. In addition to traditional services, the Social Work Team including social service students, spend less time in daily patient contact and more in intimate contact with families and physicians. The combination of these emotional and social factors both emphasizes and

augments the medical social worker's function. Among the important things required of her, in selected cases are:

1. Daily patient contact to make up for less contact with family figures.
2. Intense family contact because of the threat to life.
3. Much more contact with the physician; especially concerning plans for future medical treatment.
4. More contact with social agencies.

When the patient is a child this usually means a great deal of direct work with him and his family. If pediatric social work is to continue to meet the needs of these patients more personnel will be needed. Social work departmental budgets will have to be larger to meet the cost of additional phoning and travel to see families and agencies. Consideration will have to be given to having social workers go along in helicopters when patients are picked up and then having the worker remain with the family, if needed, when the initial impact of the accident is greatest. The needs of the child-patient consideration will have to be given to twenty-four hour social work staffing.

Procedures will have to be developed with community agencies so that they become accustomed to dealing with patients and families who receive emergency and long-term hospitalization some distance from home. In short, while the advent of new emergency medical services and procedures is saving children, it is also putting tremendous social and emotional pressure on their families. The pediatric medical social worker steps in to fill this gap based on a knowledge of individual and family dynamics, the social factors that affect people's lives, and an ability to locate and coordinate community resources so that they serve the interest of the patient and his family.

## **THE CHILD LIFE PROGRAM**

*Douglas Dixon*

A full understanding of Pediatrics would be incomplete without looking at efforts to help children and their families adjust to hospital life. The Child Life Program was created because we recognize that the emotional effects of hospitalization are too important to leave to chance. When a child is in the hospital he is in a strange place, separated from his family and concerned about getting well. In addition, parents are naturally worried about their child, especially if they may not be able to stay with him. They often are as bewildered as their child when confronted with the

confusion of hospital life. Doctors and nurses are sensitive to the needs, but there are so many needs that require attention. Who can stay with a crying boy or girl when Mommy has to leave? Who can promise a child that there will be time to play? Who can make sure that there will be stimulating activities? Who can handle the problem child? And who can encourage the parents to feel welcome or reassure them that their child will not be left alone?

The Child Life Program works by having a professional staff organize a flexible play program in activity rooms and on the children's wards. The core of the program revolves around the Child Life teachers. They are trained in education or a related field, and they are assisted by part time workers, student teachers, and by volunteers. Each teacher is responsible for a daily program in a particular area of pediatrics. Such areas include an infant and toddler wing, a pre-school and early-school age wing, and a floor for pre-teens and adolescents. In each of these areas there is a Child Life activity room geared to the age of the children. Thus, in the toddler room there is a large floor mat surrounded by push and pull toys, blocks, and a sliding board. In the playroom there are art tables and open shelves with trucks, puzzles and games. The older children, on the other hand, have a pool table and a work bench in their activity room plus lounge furniture and a hi-fi system. In addition, each teacher takes advantage of a full size gym connected to the pediatric floor, where there is also an outdoor porch and courtyard. Here hospital versions of baseball and volleyball mix with lots of running around and noise, as active children, children with IV's and children in wheelchairs play together.

The day is roughly divided between structured morning activities, a quiet time at mid-day, and informal activities in the afternoons and in some of the evenings. The morning is for art projects, group teaching, story time, singing, lunch in the playroom, and gym time. Quiet time is when individual attention can be given to children confined to their rooms. Afternoons usually are for fun and games, perhaps a party or a movie in the rotunda, where ambulatory children, bed patients and families can be brought together. The atmosphere throughout the day in Child Life is relaxed so that patients, visitors and staff feel at home with whatever is going on, while allowing the children to be themselves. And since it is in a hospital, the program covers holidays and weekends.

But what exactly is Child Life? The question is often asked, "Is Child Life entertainment?" No. Child Life is caring; Child Life is gearing the hospi-

tal to children; Child Life is made up of laughing, running, shouting, touching, crying, sharing. It's a lot of ways of showing that the children in pediatrics are important. It's allowing for the attention children demand. This means winning over happy children, spoiled children, problem children, retarded children, withdrawn children, very sick children—and gaining their respect and trust. It means being a friend and a disciplinarian. It means showing the pediatric staff through example that the children come first. It means believing that every child can be reached in some way. And a large part of Child Life is creating a haven for children in Pediatrics—some place away from needles, where there is someone whose presence can be counted upon, someone whose time is not divided, someone who sees that a child is treated consistently because of an understanding of what makes children tick.

In short, the department of Pediatrics shows much of its love of and concern for children by making sure there is room for what makes children happy in each day of the child's hospitalization. The Child Life Program is really an extension of the department's encouragement to parents to stay overnight with their child or to visit at any time, just as it is reflection of the department's efforts to have colorful hallways and bedrooms for the children. The connection is the spirit that the Child Life staff tries to generate, a spirit hopefully felt by the family and the pediatric staff toward all of the children in Pediatrics. The department believes that a loving program shows through the confusion and the sadness of being in the hospital. The department hopes that from the child's point of view, part of being in the hospital is wanting to get better, because people try to understand you and treat you for what you are, a child.



This is the usual level of activity in one of the rooms of the Newborn Intensive Care Unit with infants on monitors, respirators and receiving intensive medical and nursing care. The blurred face in the far rear belongs to Dr. Ronald Gutberlet, Director of the Newborn Service.

## A STUDENT'S VIEW

Edward Morris

Very shortly after entering medical school, in fact, the afternoon of the very first day, I found myself walking down the hallowed halls of the Bressler Building. As I passed the anatomical specimens along the wall, I was suddenly hit by a ghastly odor, followed by a shocking sight. There, before me, lay 40 human beings, neatly spread out on individual tables, reeking of formaldehyde. My cadaver was an interesting looking gentleman, mustachioed, with large hands and feet. I wondered what kind of life he had led, where he was from, how old he was, what he had died from, and wouldn't it be something if someone in my class recognized him. It wasn't very long though, before I was intently looking for the tendon of the flexor pollicis longus muscle, and trying not to cut the median nerve, and my questions were soon forgotten. Unbeknownst to me, I was well on my way to becoming desensitized.

Anatomy was followed by the blood and guts of autopsies, and the unforgettable buckets of pickled organs. As I stood with my classmates watching our first autopsy, there were many sick looks on our faces. However, they soon disappeared; after all, we're medical students, this stuff doesn't bother us.

It was not long before third year rolled around, and I was taking Pediatrics. I found myself confronted with approximately 20 very tiny and very sick children. I desperately searched back through the past two years for the classroom knowledge and the physical diagnostic techniques to deal with my new patients. My search was brief and unsuccessful, and I soon found out that my little patients were going to be my teachers. Very quickly I learned that what my patients needed most, was someone acutely sensitive to their needs, and plenty of love. How strange, I thought, I had just completed two years of learning to become insensitive.

One of my first patients was Lisa, a precious little girl of two. On several previous admissions she had been diagnosed as having widely disseminated neuroblastoma, and her prognosis was poor. I studied her chart, and digested the scores of tests along with their results, and the pages of notes made by many physicians. When I felt that I had a pretty good grasp of the situation, I grabbed my black bag, and confidently marched down the hall to obtain an up to date history from Lisa's parents. As I entered the room, I suddenly lost all of the confidence I had built up coming down the hall, as well as much of my composure. There was little Lisa, in the arms of her mother, with her

father sitting in the adjacent chair. Several things hit me all at once. Lisa's parents couldn't be any older than me; and the thought that kept pounding away within me, was that this little girl, so lovingly held by her mother, was going to die. I introduced myself and sat down, and began asking my questions in what I hoped was a very professional way. I knew that Lisa's parents were completely aware of her disease, and the small chance she had. But, I could not stop wondering how they must feel, putting myself in their position. It took everything I had to hold back the tears that kept welling up in my eyes. As I continued with my questions, I thought that soon I am going to be a physician, a pillar of strength, a consoling shoulder to cry on. Boy, was I doing a lousy job.

When I look back on that experience now, I realize that Lisa's parents surely realized what was going on within me, and that they had the situation well under control. It was their understanding that got me through. I only hope that other students may have such an experience, and I keep wondering, what will it be like for me, the next time.

#### A RESIDENT'S VIEW

*Mimi Turner, M.D.*

Being Pediatric house officer at a large University Hospital means being busy. However every rotation is a different "kind" of busy. If it's your rotation in the nursery it is the pleasure of examining many new pink screaming babies in the Full Term Nursery contrasted with the hours of time caring for a critically ill two-pound premature on a respirator for treatment of hyaline membrane disease. If it's your rotation in the CPC, it's learning about the community. The CPC offers an opportunity to see how a center equipped for total pediatric care functions as well as experience working with a team of PHN's, social workers and psychologists.

Most of all during this rotation you learn what it's like to be a pregnant unwed teenager or to live in a project in the inner city. From the outpatient department to the wards the experience constantly varies in emphasis. After a while the Emergency Room becomes less frightening; you learn how to treat the common problems and realize that fortunately, a truly seriously ill child is not going to walk in every hour. Nonetheless the hours and pace are grueling so that by the time you rotate to an inpatient service you're glad to leave behind the 24-hour clinic and concentrate on a few patients in depth. Whereas the clinic is a place to see common pediatric problems in children of all age groups, the ward experience offers

a more academic atmosphere with children of defined age groups who are often referred for complicated diagnostic work-ups. But it is exciting to be involved in the investigation of a rare disease as it is to see a one month old with dehydration get better. That's one of the things about Pediatrics—the wide spectrum of disease, much of which you can do something about. Certainly it is with some of the chronically ill or dying children that many of your ward hours are spent. It is here very often that every inch of your medical skills and more so, your human sensitivities are taxed. To deal with the double burden of helping a child die and helping the parents to let go is overwhelming. It brings you out of the world of LDH isoenzymes and complement back to the nitty-gritty of birth and living and dying, of being human.

And being human is what it's all about. I wouldn't be honest if I didn't say that after starting IV's all night or seeing colds and sore throats in the wee morning hours that children and parents can get on your nerves and in those early morning hours I wonder if there isn't a healthy child somewhere or a mother who can cope somewhere or a better medical care system somewhere or some toothpicks to prop open my eyelids and some coffee to fill my growling stomach.

You have to dig children to be in this business. It's those little squirmers who coo and squeal, those bigger toddlers who are sure they're the center of the universe and the adolescents who are sure their parents are a lot of "who struck Harry" - remember that feeling? - that make me keep busy and like it.

#### SUMMARY

*Marvin Cornblath, M.D.*

Each segment of the Department has presented a thumbnail sketch of its current activities. All are available to every child of the State of Maryland. I hope that you will take advantage of your Department of Pediatrics and participate in its desire to serve you. Each service and activity has been described by the person involved with it. Although fragmented and different, each seeks excellence along with concern and love and is equally important in this Department. Our hope is to continue to serve you and to improve our ability to better understand children in health and disease.

*Ed. Note:*

*Dr. Cornblath is Professor and Chairman of the Department of Pediatrics.*

*Dr. Schaffer is a Visiting Professor in the Department of Pediatrics.*

*Photos by Philip Szczepanski*

## Baltimore Campus Allied Health Schools

# Progressive Dental Hygiene Education at the U. of M.

JoAnne Ivory Pepin, R.D.H., B.S., M.P.H.

Many people on the Baltimore Campus may not realize that the School of Dentistry is the oldest dental school in the world. What may be equally as interesting is the fact that the education of one of dentistry's most important health professionals, the dental hygienist, was not initiated at the School of Dentistry until 1970.

Dentistry presently has four identifiable health professionals: the dentist, the dental hygienist, the dental assistant, and the dental laboratory assistant. Each of these individuals has specified responsibilities in the provision of comprehensive dental care to the public. In addition, much experimentation is currently being undertaken in this country and in others relative to delegating additional patient care responsibilities to the dental hygienist and the dental assistant in order to provide more dental care of higher quality to more people.

The School of Dentistry offers formal educational programs for dentistry and dental hygiene. Of the four dental health professionals previously mentioned, the dentist and the dental hygienist are the only two which are presently required to be licensed in order to provide patient care. This article will discuss dental hygiene only.

The dental hygienist is responsible for performing preliminary diagnostic and preventive procedures in order to assist patients to achieve and maintain optimal dental health. These procedures consist of performing a medical and dental history, conducting an oral examination, exposing full mouth radiographs, identifying and recording the evidence of dental diseases, obtaining additional diagnostic information such as impressions for study casts, caries activity tests, vitality tests, nutritional deficiency tests, and oral cytological smears. A key aspect of the preventive services which dental hygienists provide is in the performance of the complete prophylaxis. This consists of, in addition to the preliminary diagnostic information, removing deposits and accretions from the surfaces of teeth and restorations through scaling, root planing, cleansing and polishing procedures. At the completion of the prophylaxis, applications of caries preventive agents may be applied if deemed necessary. A highly vital aspect

of the dental hygienist's services is the responsibility for communicating to the patient his or her role in preventing future dental disease. The dental hygienist must identify to the patient the evidence of present or potential disease in the patient's mouth and then motivate the patient to follow certain practices in order to prevent the onset of new dental disease.

The education of dental hygienists must be in formalized programs approved by the Council on Dental Education of the American Dental Association. The curriculum may consist of either two or four years. Two year curricula exist in community colleges and lead to an Associate of Arts degree. Four year curricula are seen in colleges and universities and lead to a Bachelor of Science degree. The primary difference between two and four year programs is in the two years of pre-dental hygiene courses required of four year curricula. The last two years of the four year dental hygiene curriculum is very similar in most programs to the entire curriculum of two year programs.



Junior Dental Hygiene student performing a prophylaxis on a patient in the Dental Hygiene clinic.

The University of Maryland School of Dentistry initiated a four year dental hygiene program and enrolled its first class of eleven students in September of 1970. Although the program is based on specific objectives, the following goals and principles are reflected in the curriculum:

1. To increase the supply of dental manpower.
2. To contribute to the quantity and quality of preventive and educational dental services available to the public.

3. To promote the utilization of dental hygienists as members of the dental health team.

4. To contribute to educational experimentation in the development of curricula to prepare auxiliaries to perform additional intra-oral procedures.

5. To provide an opportunity for certified dental hygienists to obtain Baccalaureate degrees.

6. To establish a foundation for the development of a graduate curriculum for dental hygienists at the University of Maryland.

7. To provide continuing education programs for active and inactive licensed dental hygienists.

8. To recruit and admit students of the highest achievement and aptitude for enrollment in the dental hygiene curriculum.

9. To work with organized dentistry and other health agencies in the establishment and advancement of the dental hygiene profession in Maryland.

10. To participate in community health programs and educational activities for the promotion of optimal health of the public.<sup>1</sup>

A number of innovations in dental hygiene education at the University of Maryland have been instituted since the initiation of the program. Curriculum planning developed from discussions of what duties and responsibilities dental hygienists have or could have, and what knowledges and skills students should receive in order to be able to completely perform their tasks. One of the key ideas was that early clinical application should be built into the curriculum to allow for maximum reinforcement of didactic material. Courses were structured into blocks of time so that didactic and clinical content material could be presented conjointly. The clinical application allowed the student to see the interrelationship between what he or she was learning in the classroom and its significance in the clinical practice of dental hygiene. The students have had previous pre-dental hygiene science courses, specifically Chemistry, Human Anatomy and Physiology, Microbiology, and Nutrition, in addition to others. As a result, content and clinical application of specific courses was able to be developed in view of the fact that the students had a common core of basic science information. This allowed the opportunity to present more in-depth material earlier in Maryland's program than is possible in more traditional dental hygiene programs.



Dental Hygiene instructor provides supervision of instrumentation procedures.

Since clinical application was a central innovation, early patient contact became essential to the continuity of the curriculum. Traditionally, dental hygiene students spent an entire semester learning and practicing instrumentation skills on manikins. Live patient exposure was often not until midway into the second semester of the curriculum. Dental hygiene students at Maryland use manikins primarily for dental anatomy only, and learn and practice their basic dental hygiene skills on their classmates prior to seeing real patients. Students schedule real patients only after they have demonstrated minimal proficiency levels on a classmate. For the faster students, this has been about six weeks after beginning the program. This approach requires a good faculty-student ratio, but has resulted in students being able to progress more at their own rate.

The necessity for a mastery level type of clinical evaluation system became obvious in order to implement a more self-paced type of dental hygiene curriculum. This necessitated that the dental hygiene faculty develop evaluation mechanisms for each task to be performed, and then identify what specific steps were required to correctly perform each one of the identified tasks. This proved to be an enormous undertaking, but it is now nearly complete and has proven to be very valuable in terms of being able to identify where students' strong and weak areas are. It is anticipated that through appropriate utilization of proficiency evaluations, individualized and self-paced learning of dental hygiene skills and knowledges will become a reality.

<sup>1</sup>A Proposal for the Establishment of a Baccalaureate Degree Curriculum in Dental Hygiene. Unpublished.

*Ed. Note: Mrs. Pepin is Assistant Professor and Chairman of the Department of Dental Hygiene at the University of Maryland School of Dentistry.*

# PRESIDENT'S MESSAGE

Robert B. Goldstein, M.D.



The Medical Alumni Association of the University of Maryland is entering into its Centennial Year, and I am honored to be a part of an organization that has "weathered the storm" for a century. As I assume the office of President, I shall endeavor to carry out the plans laid out by my predecessors.

With the appointment of John M. Dennis, M.D., as Dean of the School of Medicine, one of our own alumni, we are looking forward to a closer relationship with this office. During his year as Acting Dean, Dr. Dennis was most cooperative with the Medical Alumni Association and placed many of our members on important functioning committees. This past year has shown us that the Alumni Association and the Dean's office can work together for the benefit of the Medical School.

The restoration of Davidge Hall is no longer a dream. The building has been entered on the Register of Historic Places with the Federal Department of the Interior, the pledges are coming in, the alumni are showing interest in the project, and it is gaining momentum.

At present, plans are underway for the initial survey to be made by Kelly Associates, Inc., which will include the opening of walls, ceilings and floors for examination, X-ray analysis of hidden construction, mortar and paint chip analysis and comparison with documentary evidence. When the next issue of the *Bulletin* is published, we should be able to give you detailed information on their findings.

In order for the restoration to become a reality, we need the backing of all members. Over 400 years ago Francis Bacon wrote: "Use the memory of thy predecessor fairly and tenderly, for if thou dost not, it is a debt will sure be paid when thou art gone." This is still apropos today and, if each member will pledge his support to the Davidge Hall Restoration Fund, what fitting homage we could pay to those medical pioneers who made it possible for us to gain our training and knowledge at the University of Maryland Medical School.

The *Bulletin* is a significant line of communication between the Hospital, School and Alumni Association, and it is most fortunate for us that Dr. George H. Yeager accepted the editorship of this publication this past year. As many of you know, Dr. Yeager has had a vast amount of experience along these lines, and we are most grateful that he is continuing to give his full support to the Medical Alumni Association.

Alumni Day next year will be Wednesday, May 28 1975. If you are not aware of the fact, this will mark the 100th Anniversary of the Medical Alumni Association of the Medical School. Mark your calendars now—this is the year to return. If you haven't attended a reunion recently, won't you please join us and see the progress that has been made and the changes that have occurred on the campus and help us celebrate this historical occasion. Arrangements are already underway and you will receive communications from the Alumni office in the future regarding details of our Centennial Year program.

The Alumni Association cannot possibly grow and become the vibrant organization we envision without the participation of all our members. It needs your support, interest, suggestions and loyalty.

I personally feel that any success I have achieved in life I owe to the opportunities given me by the University of Maryland Medical School, for which I shall be ever grateful and loyal. I ask you to recall the Preamble of the Constitution which states: "We, the Alumni of the School of Medicine of the University of Maryland, desiring to further the interest and advancement of the University of Maryland School of Medicine and to perpetuate the associations made during the medical school period, do hereby adopt this Constitution for the governing of the Medical Alumni Association." If each alumnus would reaffirm his allegiance to this statement, a strong, influential and important body could emerge.

The Medical Alumni Association is 100 years old—let's make it a year to remember. Get involved, become interested, submit suggestions and support your Association—it needs YOU.

## GOLD KEY 1974



### THEODORE E. WOODWARD, M.D.

On May 30, 1974, the University of Maryland Alumni Association honored Theodore E. Woodward, one of its most distinguished graduates by presenting him the Medical Alumni Honor Award and Gold Key.

Dr. Woodward, a native of Westminster, Maryland, received his B.S. degree from Franklin and Marshall College, 1934, and his M.D. degree from the University of Maryland, 1938.

Following four years of graduate education, he returned to the University of Maryland in association with the late Dr. Maurice C. Pincoffs. He rose through the academic ranks and became Professor and Head of the Department of Medicine in 1954. Dr. Woodward is well known nationally and internationally and as a result has received many awards and academic honors. His primary interest and devotion have always been directed toward his academic responsibilities, this being attested to by the fact that he received the Gold Apple Award for Clinical Teaching, 1967, 1973, and 1974.

"Ted", as he is affectionately known, married a classmate, Celeste Lauve in 1938. They have three children, all of whom have followed in their parents' footsteps by becoming M.D.'s. Celeste herself has played an important role in contributing to Ted's success, and at the same time, has achieved an independent and outstanding record as a clinician, not only in the University of Maryland Hospital but also in Pakistan and Korea.

The Medical Alumni Association by presenting its Honor Award and Gold Key to Ted Woodward has given due recognition to one of its most illustrious sons.

## CLASS OF 1959

The Fifteen-Year Reunion of the Class of 1959 of the University of Maryland School of Medicine was held at the Cross Keys Inn on May 31, 1974.



FIRST ROW: Joseph Nataro, Gerard L. Russo, Beverly J. Stump, Carol E. Rybczynski, Stanley S. Schocket. SECOND ROW: Robert C. Irwin, Carlton I. Halle, Paul Koukoulas, Karl M. Green, Elmer S. McKay, Howard J. Rubenstein, Morton Mower, Hans R. Wilhelmsen, Arthur A. Serpick. THIRD ROW: Stanley Z. Felsenberg, Jorge O. Just, Raymond F. Roig, D. R. McWilliams, Ferdinand Mainolfi, Richard C. Lang, Harvey M. Solomon, Isidore G. Ances, S. J. Demarco.

## TWENTY-NINERS HAVE SUCCESSFUL REUNION

The Class of 1929 conducted a very successful reunion program celebrating the forty-fifth anniversary of their graduation from the University of Maryland School of Medicine.

The following physicians and their wives attended the program: Silvio Alessi, Selig Brauer, Earl Chambers, Joseph Corsello, Jacob Garber, John Haney, Leroy Heck, Ernest Levi, Irving Morgan, Maurice Porterfield, Morris Schreiber, Glenn Speicher, William Sullivan, Charles Wallack, and William Yudkoff. Attending alone were Walter Levy, John Reilly and Hugh Ward. Rafael Vilarlsern was accompanied by his son.

# ALUMNI DAY 1974

Approximately 125 members of the Medical Alumni Association attended the Maryland Medical Reunion and Alumni Day Activities on May 29, 30 and 31, 1974.



Dr. John M. Dennis, Dean, and Jack C. Robinette, Administrator of University of Maryland Hospital, at the cocktail party in the courtyard.

On Wednesday evening, a cocktail-hospitality party was held in Davidge Hall and the adjacent courtyard.

The opening exercises and annual business meeting, with Dr. William J. R. Dunseath, President, presiding, were held in Chemical Hall on Thursday. Addresses were given by Dr. John M. Dennis, Dean of the School of Medicine, Dr. Albin O. Kuhn, Chancellor of the Baltimore Campus, and Dr. Dunseath, President of the Medical Alumni Association, who spoke on the futures of the School of Medicine, the Baltimore Campus and the Medical Alumni Association, respectively.



Dr. & Mrs. Theodore E. Woodward chat with the Chairman of Alumni Day.

Following the election of officers and board members, changes in the Constitution and By-laws were approved.

After a luncheon in the Student Union Building, the scientific sessions of the University of Mary-

land Hospital Medical Association, the Department of Obstetrics and Gynecology, the Bradley Pediatric Society, the Department of Psychiatry and the University of Maryland Surgical Society took place.

The evening activities commenced with a Reception for the Fifty-Year Graduates in the Main Ballroom of the Baltimore Hilton. Highlighting the annual banquet and dance that followed was the presentation of the Honor Award and Gold Key to Dr. Theodore E. Woodward.



A toast by four Fifty-Year Graduates. L-R: Dr. Arnold L. Tabershaw, Dr. Joseph Knox, Dr. John Zazlow, Dr. Anthony Scimeca.



Dr. Robert B. Goldstein accepts Presidency of the Medical Alumni Association and congratulates Dr. William J. R. Dunseath for his outstanding performance during his term as President.



Chancellor & Mrs. Kuhn (L) greet Dean & Mrs. Dennis at the banquet.



Dr. Dunseath, President of the Medical Alumni Assn., (R), presents Honor Award & Gold Key to Dr. Theodore E. Woodward.



Dr. Salvatore Donohue, Chairman of Alumni Day, and Mrs. Donohue at the banquet.



Dr. & Mrs. Umberto Villa Santa stroll in the courtyard under the Japanese lanterns.



Dr. Anthony Scimeca joins Dr. Vernon Krahel in a duet.

## Attention—Mark Your Calendar

### ALUMNI DAY, 1975

Traditionally, Alumni Day has been held on the Thursday before Commencement. Because of the observation of the Memorial Day holiday by the State of Maryland on Friday, May 30, 1975, it has become necessary to plan Alumni Day activities for WEDNESDAY, MAY 28, 1975.

Mrs. Umberto Villa Santa, in memory of her father, Dr. Frank C. Marino, is having the old anatomical drawings restored. They will become an important asset to Davidge Hall. Davidge Hall has now been officially named in the Federal Registry as a national historical landmark.

### THE DOCTOR JOSEPH LIPSKEY LOAN FUND

The University of Maryland School of Medicine is proud to announce the establishment of The Doctor Joseph Lipskey Loan Fund which will be used to provide financial assistance to medical students on the basis of financial need and academic standing.

The loan fund will be a revolving one and will initially be made to a needy student during the 1974-75 academic year.

# UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

## Class of 1974

### DOCTOR OF MEDICINE

January 31, 1974

Barbara Anne Cochran  
Stephen Baer Fleishman  
Daniel Karl Foss  
Jean Werner Helz  
Mary Catherine Hilton  
Charles Michael Jaffe  
Susan Roseanne Panny  
Jay Allen Phillips  
Bruce Linthicum Regan  
June Kerswell Robinson  
Bruce James Rounsville

### DOCTOR OF MEDICINE

May 31, 1974

Charles Philip Adamo  
Jonathan Bedri  
Michael Ray Behre  
Samuel Irvin Benesh  
George Edward Berley  
Ira Joseph Berman  
Lynn Marie Billingsley  
Richard Warren Bittrick  
Jeffrey Peter Block  
Richard Alan Block  
Gary Deaver Boston  
Stephen Alan Branning  
Joseph Edgar Bush, Jr.  
Alan Lee Carroll  
James George Chaconas  
Randolph Philip Christianson  
William Carl Crawford III  
James Edward Crook  
Jeffrey Deitz  
Frederick Lawrence Dewberry  
Thomas Charles Doerner  
Julius Eliezer Edlavitch  
Timothy Howard Eskridge  
Susan Elizabeth Ford  
Linda Weiserman Frank  
Alan Edward Gober  
Barry Steven Gold  
William Laureano Gonzalez  
Kenneth Marvin Goodwich  
Edward Stanley Gratz  
Christopher Grochmal

Robert Miller Guthrie  
Charles A. Haile  
Gary Leigh Hardegen  
Donald Burke Haskins  
James Frederic Hatch  
Charles Barry Hatton  
Michael Howard Hotchkiss  
Leroy James Huffman  
Jay R. Jackson  
John Robert Johnson  
Yvonne Edith Johnson  
Mark Steven Kaplan  
Ronald Kaplan  
Robert David Katz  
Allan Stephen Kaufman  
James Paul Keogh  
Kenneth Donald Keys  
Mark Steven Klein  
Laslo Emory Kolta  
Carole Sue Kornreich  
Karol Susan Kosnik  
Celia A. Kramer  
Steven M. Lacher  
Albert Mang-Lum Lai  
Howard Gary Lanham  
Marc Irwin Leavey  
Steven Alan Levenson  
Philip Alan Levin  
Merral Barrie Lewis  
Arthur Ping Liang  
Andrew Monroe London  
Lillian Josephine Love  
Bruce Gerald Lowman  
Terrance Patrick McHugh  
James Joseph McMillen  
Manuel Antonio Machiran  
Kenneth Leslie Malinow  
Stuart Ottmar Marcus  
Gail Lynn Marston  
John Risser Marin  
Libero Louis Marzella  
Stephen Ronald Matz  
Stephen Elliot Metzner  
Ernest Burton Miller  
Joel Brian Miller  
Paul I. Miller  
Sheldon Dale Milner

Thomas Miller Milroy  
Barbara Diana Milton  
Dennis Anthony Niner  
Dawn Victoria Obrecht  
Philip Patrick O'Donnell  
Robert William O'Donnell  
Eric Smith Orwoll  
Jeffrey Mark Pargament  
George Branch Patrick III  
Edward Lee Perl  
Luis Anibal Queral  
Clayton Lee Raab  
Bannister Lee Raines, Jr.  
Louis Nathaniel Randall  
James Moore Raver  
Sue Vauthier Raver  
Michael Eugene Reichel  
Richard Bruce Rosher  
Ann Elizabeth Ruderman  
Michael Stephen Rudman  
J. Michael Schnell  
Harvey Neil Schonwald  
Paul Schwartz  
Edward Neil Sherman  
Madelyn Jane Siegel  
Mitchell Todd Smolkin  
Robert I. Solenberger  
Jeffrey Stuart Sollins  
Jessie D. Stahl  
Harry Stanley Stevens  
Lawrence Robert Swink  
Ernest Gobert Szechenyi, Jr.  
Lawrence Norwood Thompson  
William Albert Valente  
Elise Willem van der Jagt  
Rolando Guillermo Vieta  
Steven Alan Vogel  
Emerson Coleman Walden, Jr.  
Thomas Eugene Walden  
Laura Jean Bradford Waldron  
Vincent D. Waldron  
William Raymond Weisburger  
Michael Henry Wojtanowski  
Stephen Nicholas Xenakis  
Robert Stephen Yasner  
Allen Charles Zechowy  
David Leslie Zisow



## *DAVIDGE HALL IS A PRICELESS HERITAGE —SUPPORT ITS RESTORATION!*



Davidge Hall represents the origin of formal medical education in Maryland. Medicine is still being taught in its halls. Help restore this building to its original beauty. Send your contributions to the Davidge Hall Restoration Fund c/o Maryland Medical Alumni Association, 522 West Lombard Street, Baltimore, MD 21201.

## **Faculty News**

### **New Appointment, Promotions & Resignations**

Jo Anne Earp, Sc.D., Research Assistant—  
SOCIAL AND PREVENTIVE MEDICINE (appointment effective 3-4-74) 12 East 33rd Street; Baltimore, Maryland 21218; 235-2932.

Thomas H. Held, Mr., M.S., Ed.D., Instructor & Director of Media—OFFICE OF MEDICAL EDUCATION (appointment effective 3-18-74) address not available yet.

Ibrahim Turek, M.D., Clinical Assistant Professor—PSYCHIATRY (promotion effective 7-1-74) 3702 Gardenviwe Road; Baltimore, Maryland 21208; 484-1613.

Ruth E. Luddy, M.D., Assistant Professor—PEDIATRICS (promotion effective 2-1-74) 823 Trafalgar Road; Baltimore, Maryland 21204; 821-6860.

John B. Herts, M.D., Assistant Professor—PSYCHIATRY (appointment effective 1-9-74) 2507 Willow Glen Drive; Baltimore, Maryland 21209; 358-0122.

Robert T. Rinaldi, M.Ed., Assistant Professor—PEDIATRICS (promotion effective 2-1-74) 1332 Woodbourne Avenue; Baltimore, Maryland 21239; 532-9416.

Judith Haran, M.S.W., Instructor—PSYCHIATRY (appointment effective 1-1-74) Rt. 1, Box 304, Oakland Road; Sykesville, Maryland 21784; 795-2867.

William C. Weintraub, M.D., Assistant Professor—FAMILY MEDICINE (appointment effective 7-1-74) 25 Lakeside Drive; Greenbelt, Maryland 20770; 474-6443.

Aristides C. Alevizatos, M.D., Assistant Professor—FAMILY MEDICINE AND MEDICINE (promotion effective 2-10-74) 5 Merryman Court; Baltimore, Maryland 21210; 366-5053.

Walter Blumenfeld, Mr., Associate—SURGERY (appointment effective 1-28-74) R.D. 4, Box 19; Severn, Maryland 21144; 969-2260.

Ruth E. Backus, M.D., Instructor—MEDICINE (appointment effective 2-1-74) 8709 Hayshed Lane; Columbia, Maryland 21045; 730-0557.

Vincent J. Fiocco, M.D., Instructor—MEDICINE (appointment effective 1-1-74) 257 Winchester Drive; Westminster, Maryland 21157; 848-2723.

Jack L. Mason, Ph.D., Assistant Professor—OFFICE OF MEDICAL EDUCATION (appointment effective 3-12-74) address not available yet.

Mona D. Delinic, M.D., Attending Physician—PEDIATRICS (appointment effective 2-1-74) 3 Cross Keys Road; Baltimore, Maryland 21210.

Richard A. Cash, M.D., M.P.H., Assistant Professor—MEDICINE (appointment effective 3-1-74) 1755-C Champlain Drive; Baltimore, Maryland 21207; 944-2290.

William J. L. Bradley, Instructor—PHYSICAL THERAPY, resigned 5-31-74.

Francis W. O'Brian, Executive administrator—MEDICAL ALUMNI, resigned 4-30-74.

Morris S. Lasson, Assistant Professor—PEDIATRICS, resigned 12-31-74.

Olga E. Ortiz, Post Doctoral Fellow—BIOPHYSICS, temporary appointment, terminated 4-14-74.

Patsy R. Hines, Research Assistant—SOCIAL AND PREVENTIVE MEDICINE, resigned 3-29-74.

Phillip Hagan, Instructor—MEDICINE, resigned 9-14-73.

Harvey A. Lewis, M.D., Clinical Assistant Professor—PSYCHIATRY (appointment effective 7-1-74) 6303 Mossway Road; Baltimore, Maryland 21212; 435-4260.

Helm Stierlin, M.F., Ph.D., Associate Professor—PSYCHIATRY (appointment effective 1-1-74) 6012 28th Street; Washington, D.C. 20015; 202-362-5506.

Frances P. Day, B.S.N., M.S., Research Assistant—SOCIAL AND PREVENTIVE MEDICINE (appointment effective 3-18-74) 1803 Eutaw Place; Baltimore, Maryland 21217; 523-9521.

Richard A. Cash, M.D., M.P.H., Instructor—SOCIAL AND PREVENTIVE MEDICINE (appointment effective 3-1-74) 1755 C. Champlain Drive; Baltimore, Maryland 21207; 944-2290.

Blanche M. Dicus, Optician—associate—OPHTHALMOLOGY (appointment effective 4-29-74) 3 Oakwood Road; Baltimore, Maryland 21222.

Marilyn Kay Cosby, D.D.S., Instructor—PEDIATRICS (appointment effective 3-10-74) 550 N. Broadway, Apt 808; Baltimore, Maryland 21205; 327-0036.

Elynore A. Cucinell, M.D., Clinical Assistant Professor—NEUROLOGY (appointment effective 2-25-74) Box 128, Edgewood Arsenal, A.P.G.; Edgewood, Md. 21010; 1-676-4030.

Harry C. Hull, III, B.A., Assistant—OFFICE OF CONTINUING EDUCATION (appointment effective 3-1-74) 4909 Roland Avenue; Baltimore, Maryland 21210; 467-9395.

Charles H. Peddicord, Research Associate—CLINICAL PATHOLOGY (appointment effective 4-21-74) 6016 Chesworth Road; Balto., Md. 21228; 788-3689

Lloyd Schwartz, Ph.D., Clinical Assistant Professor—PSYCHIATRY (promotion effective 7-1-74) 2028 Greenbury Road; Baltimore, Maryland 21209; 664-6926.

Charles J. Waechter, Ph.D., Assistant Professor—BIOLOGICAL CHEMISTRY (appointment effective 5-1-74) 143 Hopkins Road; Baltimore, Maryland 21212; 377-2970.

Edson X. deAlbuquerque, M.D., Ph.D., Professor and Chairman—CELL BIOLOGY AND PHARMACOLOGY (appointment effective 5-1-74) address not available yet.

Ronald Kornblum, M.D., Clinical Associate Professor—PATHOLOGY, resigned as Deputy Chief Medical Examiner 7-73.

Rose Last, Instructor—PHYSICAL THERAPY, resigned 6-30-74.

Margaret A. Bodine, Instructor—PHYSICAL THERAPY, terminated 6-30-74.

# ALUMNI CHATTER

William D. Hakkarien, '70, Jacksonville, N.C., has been certified by the American Board of Family Practice. Dr. Hakkarien is currently serving as Medical Officer, Family Practice Service, Naval Regional Medical Center, Camp Lejeune, N.C.

• • •

Dennis Hurwitz, '70, Wilder, Vermont, is Chief Resident in General Surgery at Dartmouth Affiliated Hospitals, Hanover, New Hampshire. He has also been recently appointed to a Residency in Plastic Surgery at the University of Pittsburgh beginning in July, 1975.

• • •

John D. Gelin, '68, Inverness, Fla., has been elected Chief of Staff of the Citrus Memorial Hospital. He is also the 1974 recipient of the Citrus County Chamber of Commerce Outstanding Community Service Award.

• • •

Don B. Vogel, '67, Silver Spring, Md., is a Diplomate of the American Board of Psychiatry and Neurology. He has served as Chief of the Department of Psychiatry and Neurology at Ft. Carson Army Hospital in Colorado Springs, Colorado, and completed his residency at the Cornell Medical Center Payne Whitney Clinic.

• • •

Lee H. Schilling, '67, Fresno, Cal., has been certified by the American Board of Obstetrics and Gynecology and is in the private practice of Obstetrics and Gynecology in Fresno, California.

• • •

Merrill I. Berman, '62, Baltimore, Md., who practices in the field of Child, Adolescent and Adult Psychiatry, has recently become a member of the American Academy of Psychiatry and the Law.

• • •

Vincent J. Fiocco, Jr., '57, Westminster, Md., was certified by the American Board of Internal Medicine in June, 1973 and was promoted to Instructor in Medicine, University of Maryland School of Medicine, in January, 1974.

• • •

Elton Resnick, '37, Wilmington, Del., has retired from the active practice of medicine and is spending the winters at Bal Harbour, Florida.

Edward D. Frohlich, '56, Oklahoma City, Okla., is presently on the faculty at the University of Oklahoma Health Sciences Center as a Professor of Medicine and Professor of Physiology and Biophysics. He was recently appointed Editor of the *Journal of Laboratory and Clinical Medicine* which is the official journal of the Central Society for Clinical Research. Dr. Frohlich still maintains his responsibilities for the Hypertension Division in the Department of Medicine which is engaged in a very active clinical and experimental research and teaching program.

• • •

Jerome D. Nataro, '46, Levittown, N.Y., has been named Assistant Professor of Clinical Surgery (Otolaryngology) at the State University of New York School of Medicine at Stonybrook.

• • •

William A. Pillsbury, Jr., '52, Baltimore, Md., was appointed Chief Physician for the Baltimore Gas and Electric Company effective May 1, 1974.

• • •

Louis F. Klimes, '32, Baltimore, MD., is now semi-retired and sees patients on a part-time basis.

• • •

Marvin S. Aron, '57, New Haven, Conn., became a Diplomate of the American Board of Plastic Surgery in 1966. In 1968, he was named Assistant Clinical Professor of Plastic Surgery at Yale Medical School and entered private practice of plastic and hand surgery in New Haven. Recently, Dr. Aron was elected to membership in the American Association of Plastic Surgeons and listed in Who's Who in the East.

• • •

Herbert H. Leighton, '53, Oakland, Md., has assumed the office as a Councilor from the Western District at the conclusion of the 1974 Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland. Dr. Leighton served his internship and residency in Obstetrics-Gynecology at the University of Maryland Hospital. In 1957, after active Army duty, Dr. Leighton entered general practice in Oakland, Maryland. Dr. Leighton is presently Secretary-Treasurer of the Medical Staff of the Garrett County Memorial Hospital and the Garrett County Medical Society. He is a member of the AAFP, Deputy Medical Examiner for Garrett County and examining physician for the C & P Telephone Company.

*Byruth Lenson-Lambros*, '27, Baltimore, Md., was among 3,000 physicians who were given the honor of Fellow in the American Academy of Family Physicians in October, 1973. She is now awaiting her 50th Alumni Reunion in 1977.

• • •

*Donald W. Mintzer*, '44, Baltimore, Md., has been appointed Chief of the Professional Staff of Church Home and Hospital. Dr. Mintzer has been on the staff of Church Home since 1949 and is presently an Associate Professor of Medicine at University of Maryland Hospital. He is a member of the Baltimore City Medical Society, the Medical and Chirurgical Faculty of the State of Maryland and the American Medical Association.

• • •

*Raymond V. Rangle*, '43, Baltimore, Md., has been appointed an Assistant Attorney General for consumer protection, securities and antitrust divisions of the State of Maryland Law Department. Dr. Rangle is a practicing attorney, practices internal medicine and directs his own clinical laboratory. He is a fellow in both the American College of Angiology and the American College of Legal Medicine.

• • •

*Harry M. Robinson, Jr.*, '35, Baltimore, Md., earlier this year directed a post-graduate seminar in Dermatology in Barbados where he conducted rounds at Queen Elizabeth Hospital. Later in March, he travelled to Hawaii for the American Dermatological Association Meeting, and in June, was a proctor for written examination of the American Board of Dermatology. He also attended the Society of Investigative Dermatology Meeting and delivered a paper at the AMA meeting.

Dr. Robinson has been the recipient of a certificate of recognition for "Outstanding Service through Dedicated Leadership as a Faculty Director" by the American Academy of Dermatology and is a nominee for the coveted Clark Finnerud Award from the Dermatology Foundation.

In September, Dr. Robinson will be in charge of the "Committee on Arrangements" for the Atlantic Dermatological Conference to be held in Baltimore. Presently, Dr. Robinson is in the process of preparing a new seminar, which will be offered by the Office of Continuing Education at the University of Maryland School of Medicine in February 1975, containing sections devoted to pediatrics, internal medicine, allergy and therapy.

*James G. Zimmerly*, '66, JD '69, Ellicott City, Md., has recently been elected to a three-year term on the Board of Governors of the American College of Legal Medicine. The College membership consists of over 300 physicians who are also lawyers.

Dr. Zimmerly has also been appointed Vice-Chairman of the American Bar Association's Committee on Law and Medicine for 1974-75.

• • •

*Michael J. Shack*, '68, Escondido, Cal., has completed his residency in Neurology at the University of Minnesota and is now engaged in private practice in Escondido, Cal.

• • •

*Frank A. Shallenberger, Jr.*, '46, Tucson, Arizona, is engaged in private practice and is an Associate Professor at the College of Medicine, University of Arizona, Department of Family Practice. Dr. Schallenberger was recently made a Charter Fellow of the American Academy of Family Physicians.

His son, Frank A. Shallenberger, III, graduated from the University of Maryland School of Medicine in 1973.

• • •

*Stanley E. Schwartz*, '41, Mt. Kisco, N.Y., has been promoted to Colonel MC USAR and has assumed command of 365th Station Hospital, a unit of the 818th Hospital Center and 77th USARCOM.

• • •

*Palmer F.C. Williams*, '27, Owings Mills, Md., retired from active practice in June of this year.

• • •

*Maj. Donald M. Baldwin*, '69, Ft. Sill, Oklahoma, was senior author in two articles published in the *Journal Bone and Joint Surgery*, April and June, 1974 respectively, entitled "Vertebral Sarcoidosis" and "Congenital Bowing and Intraosseous Neurofibroma of the Ulna."

• • •

*Irving D. Wolfe*, '68, Baltimore, Md., has completed his residency in Dermatology at University of Maryland Hospital and has opened an office in Owings Mills, Maryland.

*Michael Haney, '66, Myrtle Beach, S.C.* has been certified by the American Board of Surgery. Dr. Haney has completed his surgical residency at Emory University in Atlanta, Ga. and has served two years with the USAF. He is now engaged in the practice of General and Vascular Surgery in Myrtle Beach, S.C.

• • •

*Ephriam T. Lisansky, '37, Baltimore, Md.*, was the first practicing internist to receive the William C. Menninger Memorial Award at the American College of Physicians Meeting in April, 1974, for his distinguished contributions to the science of mental health. Dr. Lisansky was born in Baltimore and received his B.A. degree from the Johns Hopkins University in 1933 and an M.D. degree from the University of Maryland in 1937. He served an internship and residency at the Mercy Hospital and the University of Maryland Hospital 1937-1940. He was a Fellow in Pathology, 1940-1941, and a Fellow in Medicine, 1941-1942, at the University of Maryland. He served in the 142nd. General U.S. Army Hospital from 1942-1944 and was malaria and epidemic control officer in the South Pacific Theater from 1944-1945. His contributions to the control of malaria during the war and his interest in eradication of malaria are truly significant. This work led to the authoritative and official accounts of dengue fever, scrub typhus, and malaria in the South Pacific, and to studies on antimalarials for the National Research Council. Dr. Lisansky returned to Baltimore to private practice and to join the clinical faculty of his alma mater in pathology, clinical pathology and medicine. Experiences in the war and in practice led him into psychosomatic medicine and training analysis in the Baltimore Psychoanalytic Institute from 1947-1951. He also studied psychoanalytic psychiatry and psychosomatic medicine at the Psychoanalytic Institute and at the University of Maryland Psychiatric Institute. American Board Certified in medicine, he holds the rank of Professor of Medicine, and also of Associate Professor of Psychiatry at the University of Maryland School of Medicine. He was elected to the honorary medical scholastic Fraternity of AOA (1952) and was awarded a "Mastership" in the American College of Physicians in 1970. He was awarded the Medical Students Association Distinguished Teaching Award in 1969. His teaching of psychosomatics to undergraduates, as Associate Director of Continuing Education, and as Lecturer in the schools of medicine, social work, dentistry, and of law, and as advisor to commissions of the state of Maryland and the U.S. Public Health Service and the NIMH, have lent wide impact to his concepts of

methodology in his field. He has been honored by many medical societies and made an honorary member by the internists of Venezuela and Columbia, South America, by his contributions to the training of medical students and physicians in psychiatric aspects of medicine. He personally conducted eight postgraduate courses sponsored by the American College of Physicians and the University of Maryland on "Psychiatry for Internists" and participated in three similar courses at other universities. He has a special interest in the problem of chronic alcoholism. One of his recent papers is entitled, "Alcoholism—The Avoided Diagnosis." His insights into the interphase of psychiatry and internal medicine have contributed to an expanding perception of the practice of medicine. Dr. Lisansky has an unusually broad understanding of medicine from pneumococcal meningitis, malaria, and hepatitis to psychosomatic medicine and psychoanalysis. He has published over 25 papers on various medical subjects, is the past editor of two medical journals and the co-editor of a book published by Harper & Row entitled, "Psychiatry in the Practice of Medicine", which has also been published in Spanish, Italian and Portuguese. He is a master clinician and psychiatrist.

• • •

*William Quesenberry, '70, San Diego, Cal.*, completed his Chief Residency in Obstetrics-Gynecology at the University Hospital, University of California at San Diego and entered private practice of Obstetrics-Gynecology on July 1, 1974.

• • •

*Salvatore J. Demarco, '59, Baltimore, Md.*, has been appointed Chief of Surgery at Good Samaritan Hospital in Baltimore. Dr. Demarco is presently on the surgical faculty of the University of Maryland School of Medicine and is also a flight surgeon for the 135th Tactical Support Group of the Maryland National Guard.

• • •

*Joseph C. Orlando, '67, Baltimore, Md.*, has been appointed Chief of the Plastic Surgery Section at Good Samaritan Hospital in Baltimore.

• • •

*Morton L. Levin, '30, Baltimore, Md.*, is a Visiting Professor in the Department of Epidemiology at the Johns Hopkins University School of Hygiene and Public Health.

# NECROLOGY 1973-1974

Arthur A. Shawkey, M.D.	1900	William F. E. Lofton, M.D.	1926
Henry P. Carter, M.D.	1903	Albert A. Rosenberg, M.D.	1926
John L. Meeker, M.D.	1903	David Schneider, M.D.	1926
Edward W. Sprague, M.D.	1903	Francis B. Teague, M.D.	1927
Frank W. Haeltel, M.D.	1904	Theodore Kohn, M.D.	1928
John R. Lowery, M.D.	1904	Peter Pileggi, M.D.	1928
Harry A. Cantwell, M.D.	1906	Levi Wade Temple, M.D.	1928
Col. Lloyd A. Kefauver, M.D.	1906	W. F. Daniels, M.D.	1929
Elmer J. Beaulieu, M.D.	1907	Herman Cohen, M.D.	1929
Clarence C. Wiley, M.D.	1908	Albert E. Kay, M.D.	1930
William E. Martin, M.D.	1909	A. Seth Werner, M.D.	1930
Denis J. Cronin, M.D.	1910	Ralph F. Young, M.D.	1930
Harry B. Messmore, M.D.	1910	Fred D. Keller, M.D.	1930
George L. Stickney, M.D.	1910	Walter J. Keefe, M.D.	1931
William T. Gake, M.D.	1911	Thomas A. Martin, M.D.	1931
William T. Gocke, M.D.	1911	Anthony D. Crecca, M.D.	1932
Francis H. Hutchinson, M.D.	1911	William H. Eisenbrandt, M.D.	1932
Frank L. Jennings, M.D.	1911	Bernard Korostoff, M.D.	1932
Andrew Anderson, M.D.	1912	Milton B. Kress, M.D.	1932
Arthur E. Gramse, M.D.	1912	Alex A. Krieger, M.D.	1932
George A. Kohler, M.D.	1912	David W. Bellin, M.D.	1933
Charles F. Bove, M.D.	1913	Harry D. Bowman, M.D.	1933
Boyleston D. Smith, M.D.	1913	Hyman Schiff, M.D.	1933
Theodore McKinn Davis, M.D.	1914	Alfred C. Moore, M.D.	1934
W. L. Denny, M.D.	1914	Dan G. Bierer, M.D.	1935
Jess Jay Jenkins, M.D.	1914	George H. Brouillet, M.D.	1935
Joseph Lipskey, M.D.	1914	Earl H. Diehl, M.D.	1935
Elroy Thurman, M.D.	1914	Simon Katz, M.D.	1935
Antonio Fernos Isern	1915	Stuart D. P. Sunday, M.D.	1936
Edward E. Fitzpatrick, M.D.	1915	Joseph M. Cocimano, M.D.	1937
Robert B. Hill, M.D.	1915	Sydney Sewall, M.D.	1937
Harry Schnuck, M.D.	1915	Leonard Brill, M.D.	1937
Paul B. Steele, M.D.	1915	Francis Januszkeski, M.D.	1938
H. F. Buettner, M.D.	1916	Lawrence Cannon, M.D.	1939
Robert H. Noell, M.D.	1916	Ramsay B. Thomas, Sr., M.D.	1939
Gonzalez O'Neale, Jr., M.D.	1916	Weldon P. Chandler, M.D.	1940
G. A. Petrolios, M.D.	1917	Ruby A. Smith, M.D.	1940
Joseph Salan, M.D.	1917	Jose P. Garcia Blanco, M.D.	1941
B. B. McDade, M.D.	1917	W. Hamilton Sawyer, Jr., M.D.	1941
William Geyer, Sr., M.D.	1918	A. W. Adkins, M.D.	1942
Daniel Miller, M.D.	1919	Philip L. Dixon, Jr., M.D.	1942
J. Harold Underwood, M.D.	1919	Mary J. F. Hueber, M.D.	1943
William J. R. Orr, M.D.	1920	Thomas R. Williams, Jr., M.D.	1943
Joseph Pokorny, M.D.	1920	Thomas L. Morrow, Jr., M.D.	1944
William F. Weinkauf, M.D.	1921	William W. Orrison, M.D.	1946
George Wells, M.D.	1921	Allyn F. Judd, M.D.	1947
Robert D. Harmon, M.D.	1922	Francis J. Borges, M.D.	1950
Bricey Rhodes, M.D.	1922	Joseph E. O'Malley, M.D.	1950
T. C. Griffin, M.D.	1923	James N. Federick, M.D.	1955
Arthur M. Kraut, M.D.	1923	Arthur Callahan, M.D.	1971
Albert L. Anderson, M.D.	1924	Arthur E. Gramse, M.D.	1942
Morris I. Berkson, M.D.	1924	<b>Non-Graduates</b>	
Hulla Jaroslau, M.D.	1925	J. Tyler Baker, M.D.	
Joseph W. Kimbrough, M.D.	1925	Richard G. Coblenz, M.D.	
Daniel London, M.D.	1925	Frank H. J. Figge, M.D.	
	1925	Louis E. Harmon, M.D.	

# ALUMNI NEWS REPORT

## TO THE BULLETIN:

I would like to report the following: \_\_\_\_\_

## **SUGGESTIONS FOR ITEMS**

- American Board Certification
- Change of Office or Address
- Residency Appointment
- Research Completed
- News of Another Alumnus
- Academic Appointment
- Interesting Historic Photographs and Artifact
- Scientific Articles

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Class \_\_\_\_\_

Send To: George H. Yeager, M.D.  
Editor, Alumni Bulletin  
University of Maryland  
School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Maryland 21201

November, 1974

# BULLETIN

university of maryland school of medicine

**EMPHASIS: SOCIAL AND PREVENTIVE MEDICINE**



EDITORIAL BOARD

George H. Yeager, M.D.  
(editor)

Mary A. Lantz  
(editorial assistant)

John M. Dennis, M.D.  
John F. Strahan, M.D.  
Jack C. Robinette  
Robert B. Goldstein, M.D.  
Joseph S. McLaughlin, M.D.  
Gregory F. Handlir  
(ex-officio)  
Jean D. Goral  
(ex-officio)

# BULLETIN

**university of maryland school of medicine**

October, 1974

Vol. 59

No. 4

Social and Preventive Medicine	2
Theodore McCann Davis, M.D.	9
New Emphasis in Adult Primary Health Care	10
Viral Hepatitis in Pregnancy	14
The Robert E. Lee Film	16
Targeted Research or Targeted Development?	17
Application of Educational Technology	19
New Alumni Administrator	21
President's Message	22
Alumni Chatter	23
Faculty News	25
Alumni News Report	32

# Officers and Board of Directors of the Medical Alumni Association 1974-75

## PRESIDENT

Robert B. Goldstein, M.D. '54

## PRESIDENT-ELECT

William H. Mosberg, Jr., M.D. '44

## VICE PRESIDENT

Benjamin M. Stein, M.D. '35

## VICE PRESIDENT

R. T. Mendez-Bryan, M.D. '51

## VICE PRESIDENT

John H. Hornbaker, M.D. '30

## SECRETARY:

Kyle Y. Swisher, Jr., M.D. '48

## TREASURER:

John F. Strahan, M.D. '49

## MEMBERS EX-OFFICIO:

John M. Dennis, M.D. '45

Henry H. Startzman, Jr., M.D. '50

William J. R. Dunseath, M.D. '59

## MEMBERS OF THE BOARD:

Salvatore R. Donohue, M.D. '64

Miles E. Drake, M.D. '44

Joseph D'Antonio, M.D. '46

James A. Roberts, M.D. '46

Herbert J. Levickas, M.D. '35

E. I. Cornbrooks, Jr., M.D. '35

Raymond J. Donovan, Jr., M.D. '58

Wallace H. Sadowsky, M.D. '42

Robert T. Singleton, M.D. '53

## EXECUTIVE ADMINISTRATOR:

Mrs. Jean D. Goral

## Information for Contributors

**CONTRIBUTIONS:** Original typed copy, not carbon copies, and illustrations, requests for exchanges and book reviews, should be forwarded prepaid at the author's risk to the Editor of the University of Maryland School of Medicine Bulletin:

George H. Yeager, M.D., Editor

Alumni Bulletin

University of Maryland School of Medicine

Room 107 Gray Laboratory

Baltimore, Md. 21201

**PREPARATION OF MANUSCRIPTS:** Manuscripts, including references, should be typed double spaced on one side of the paper, leaving wide margins. While every effort will be made to guard against loss, it is advised that authors retain copies of manuscripts submitted. All pages should be numbered. Numbers one to ten should be spelled out, except when used for all units of measurement (time, dimension, degrees, weight, volume, dosage, etc.), percentage, and decimals; for numbers above ten, numerals should be used. Dorland's Medical Dictionary and Webster's International Dictionary may be used as standard references. Scientific names for drugs should be used when possible. Copyright or trade names of drugs should be capitalized. Units of measurement, e.g., dosage, should be expressed in the metric system. Temperature should be expressed in degrees centigrade. Contribution in a foreign language, when accepted, will be translated and published in English.

**PREPARATION OF ILLUSTRATIONS:** Black and white illustrations will be reproduced free of charge, but the publisher reserves the right to establish a reasonable limit upon the number supplied. Colored illustrations will be published at the author's expense. Black and white photographs should be presented as glossy prints. Line and wash drawings should be black, on white paper, with lettering in black India ink, large enough to be readable after necessary reduction. Large or bulky illustrations should be accompanied by smaller glossy reproductions of the same, to facilitate their circulation among the judging members of the editorial board. Illustrations should be numbered, the tops indicated, and the author's name and the title of the article in brief should appear on the back. A separate typewritten sheet of legends for the illustrations should be supplied.

**REFERENCES:** A bibliography of numbered references in alphabetical order should appear at the end of the manuscript with corresponding numbering in the text. Bibliographies should conform to the style of the Index Medicus with the exception that the last page number should be omitted, viz: author's name, title of article, name of journal, volume number, first page number, and year of publication in the order named.

## INFORMATION FOR SUBSCRIBERS

The University of Maryland Medical Alumni Association Bulletin is the official publication of the University of Maryland Medical Alumni Association and is published jointly four times annually by the University of Maryland Medical Alumni Association and the Faculty of the University of Maryland School of Medicine. Subscription price is \$5.00 per year in the United States, Canada and Mexico; and other countries \$6.00. Single copies, current and back copies, if available, are priced at \$2.00.

**CHANGE OF ADDRESS:** Please allow 60 days before date of issue for change of address. Notification should include the old as well as the new address (include Zip Code) with indications of whether the change is temporary or permanent. Please give the name of the journal. Copies will not be replaced without charge unless we receive a request within 60 days of the mailing in the U.S. or within 90 days in all other countries.

Membership subscriptions (University of Maryland Medical Alumni Association) and business relating to membership should be sent to: University of Maryland Medical Alumni Association, University of Maryland School of Medicine, Room 201 Davidge Hall, 522 W. Lombard Street, Baltimore, Maryland 21201.

The Publishers accept no responsibility for opinions expressed by Contributors.

# SOCIAL AND PREVENTIVE MEDICINE

## PROLOGUE

The historical evolution of the Department of Social and Preventive Medicine at the University of Maryland School of Medicine has followed the changing scene of medicine.

The teaching of "hygiene", as preventive medicine was known earlier, goes back to 1833 when Dr. Robley Dunglison from the University of Virginia came to occupy the chair of Materia Medica, Hygiene, and Medical Jurisprudence at this school. Dr. Dunglison placed such emphasis on the teaching of hygiene that the University of Maryland claimed to be the first American school to teach this subject (Calcott: *A History of the University of Maryland*, Maryland Historical Society).

Until 1954, there was a Division of Hygiene and Public Health within the Department of Medicine and the teaching was supervised, on a part-time basis, by the then Commissioner of Health of the City of Baltimore, Dr. Huntington Williams. In 1954, Dr. Maurice C. Pincoffs relinquished the chair of medicine at this school to become the first professor of a separate Department of Preventive Medicine and Rehabilitation, and was its head until July 1958 when Dr. George Entwistle succeeded him as a full-time chairman of the department with one other full-time member, his secretary.

Dr. Paul Richardson was the next full-time faculty member to join the department and was responsible for physical medicine and rehabilitation. By July 1970, this division had grown to the point where it was separated as an independent department, the Department of Rehabilitation Medicine, under the chairmanship of Dr. Richardson. At that time, the parent department was renamed the Department of Preventive Medicine, and that title continued until 1972, when Dr. Maureen Henderson succeeded to the chairmanship after having been a member of the faculty since 1960.

As Chairman, Dr. Henderson incorporated into the department some faculty members from the Institute of International Medicine and the Office of Health Care Programs. Consistent with such an expansion of activities, the name of the depart-



*Dr. Maureen Henderson, a native of England, is the first woman to be named a department head at the University of Maryland School of Medicine.*

ment was changed to Social and Preventive Medicine. An explanation of the current definitions of 'Social and Preventive Medicine' and their relationships to the concept of Public Health may be helpful in understanding the present functions of the department.

*Social Medicine* recognizes that medicine, in addition to being a biomedical science, is also a social science. As the determinants of disease, response to disease, patient behavior, and long-term control of health fall within the expertise of psychology, sociology, and other behavioral sciences, the scope of medicine must include this broader approach in studying the health of the populations.

*Preventive Medicine* is concerned with the search for causes of disease, with health maintenance, and the identification and care of individuals who are at special risk. These concerns are closely linked and complement those of clinical medicine. Maximizing the effect of modern therapy and the maintenance of restored health require the components of treatment, supervision, and social support. The development of appropriate training for specialized health workers

and health care teams belongs under the mandate of preventive medicine.

*Public Health* has expanded from the traditional environmental control, sanitation, and inspection. Its scope now includes advanced administrative skills in assessing health care needs for a population or a region, and the appropriate planning for them. It includes the initiation and implementation of legislative mandates relating to the environment and to certain population groups. Modern public health training includes the disciplines of economics, administration, decision-making, policy sciences, and data management. Schools of Public Health encompass in-depth training and advanced research in all these areas.

Departments of Social and Preventive Medicine within Schools of Medicine attempt to present a microcosm of those broader fields described above to students of medicine and other health-related professions.

### **Current Structure**

The department now has a total faculty of 70, including physicians, epidemiologists, biostatisticians, behavioral scientists, and others. It is divided into three divisions, each with a different primary responsibility, but all divisions have multidisciplinary faculties. Faculty members in all divisions share in the overall research, teaching, and service activities of the department.



Ideas and information are under continuous scrutiny and must be defended. Ed Driscoll, MS III, presents a design for a study of Baltimore nursing homes.

Dr. Maureen Henderson, Professor and Chairman of the Department also heads the Division of Education. Dr. Christian Klimt, Professor, heads the Division of Clinical Investigation and Dr. Wil-

liam S. Spicer, Professor, the Division of Health Services

The *Division of Education* teaches pre- and post-doctoral students in Schools of Medicine, Nursing, and Pharmacy. Formal and elective courses and supervision of individual projects are offered to medical students.

Each member of the teaching faculty also engages in research. This increases the capacity to teach methods and factual knowledge, and provides on-going programs within which pre- and post-doctoral students can learn the application of the health care sciences to the practice of medicine.

This division has close and active relationships with The Johns Hopkins University School of Hygiene and Public Health, Sinai Hospital, Provident Hospital, the U.S. Public Health Service Hospital, the Maryland State Department of Health and Mental Hygiene and the Baltimore City Health Department.

The *Division of Clinical Investigation* coordinates multi-clinic, cooperative, prospective clinical trials with emphasis on the areas of heart disease and diabetes.

Four cooperative clinical trials are in progress at this time: The University Group Diabetes Program, the National Coronary Drug Project, the Diabetic Retinopathy Study, and the Coronary Drug Project Aspirin Study. All are long-term studies with an estimated duration of 10 years.

Since the merger with the Department of Social and Preventive Medicine on July 1, 1972, the division has been increasingly involved in teaching. Its faculty has participated in the sophomore course on quantitative medicine for medical students and also took on a large share of the course on the evaluation of drugs in the School of Pharmacy.

New in the division is the Branch on Methods and Training, a group of faculty members whose competence in research design, execution, and analysis, is available to all investigators in the University. Thus, they serve to build a bridge between the clinical researchers and the Health Sciences Computer Center.

Senior staff members are widely engaged in consultative services and give advice to the National Institutes of Health, the Veterans Administration, Social Security Administration and the U.S. Public Health Service. In addition, there is close



Research programmer analyst George Bowden receiving and transmitting data at a CRT terminal for the Division of Clinical Investigation.

liaison with the Departments of Epidemiology and Biostatistics at the Johns Hopkins School of Hygiene and Public Health, the Food and Drug Administration, and the National Institutes of Health.

The *Division of Health Services* is concerned with the organization and management of primary health care delivery programs, the development of health service research and operational programs test new concepts of teaching in health professional schools, the development and implementation of monitoring systems for assessing the quality of health care as well as for fiscal and data management systems. The division serves as a consultant within the institution, the state, and sister health science centers in the fields of operations research.

#### Activities

The activities of the Department of Social and Preventive Medicine are comprised of the following:

- teaching medical students and residents
- searching for causes of diseases
- assessing the effectiveness of treatment
- developing new roles in health professions and newer methods for assessing the effectiveness and efficiency of health care systems

#### THE TEACHING

Teaching and investigative work proceed side by side at all levels of professional training.

#### Medical Students

During the summer months preceding entrance

into the medical school, students have the opportunity to attend a seminar course, given in various parts of the state. This familiarizes them with what they can expect in medical school, and analyzes the process of professionalization with its attending problems and changes in feelings and attitudes.



Clinical Investigation collects patient data from clinics throughout the country for its studies. These files are stored temporarily, left, then microfilmed for permanent storage, right.

During the first year, freshmen are introduced to the concepts, terminology, and methodology of analysis of health care systems and the characteristics which can be used to evaluate them. They undertake a field trip to private and public health care facilities, to broaden their comprehension of health-care systems. The department also teaches them to recognize the complex challenges presented by social change, and tries to enable them to analyze the legislative proposals which relate to the availability, organization, and quality of medical care.

In the second year of medical school, the course on quantitative medicine provides the skills of epidemiology and biostatistics which represent the basic tools of evaluation, be it of health care systems, of types of therapy, or of characteristics of diseases.

As each organ system is studied in a multi-disciplinary course, the attendant epidemiologic aspects of diseases affecting the organs are presented together with the clinical and therapeutic considerations.

During the summer students work intensively on individual projects with faculty supervision. The inquiries are generally related to health care problems in the U.S. but occasionally overseas projects are undertaken if travel funds are available.

In 1973 one student accompanied Dr. C. Alex Alexander, associate professor, on a study mission to Niger and recorded blood pressure levels in a randomly selected population. In 1974 a student spent the summer in Community Medicine at Nottingham University, and while in England attended the meeting of the International Epidemiologic Association.



Kendall Bennett, MS II, studied the distribution of congenital heart disease in Maryland.

## Residents

Residents in Social and Preventive Medicine work towards fulfilling the requirements for certification by the American Board of Preventive Medicine. This residency is a three-year program which includes formal studies leading to a master's degree in public health, as well as field experiences in the community through special projects.

The program differs from clinical residencies in that activities and opportunities for study are specifically selected for each candidate according to his or her interests and career goals. As a result the residents work more closely with their preceptors than with each other. A small group of faculty members with expertise in the area of study meets regularly with the resident and acts as an advisory committee.

Residents enter the department from a variety of backgrounds which may include health experiences in the Armed Forces, the Center of Disease Control, in international health or in law. In recent years residents in clinical specialty programs have elected to spend a year or two in the department's program.

Eight residents, trained in the Department during the last five years, represent in their present



Julius Zant, MS III, and faculty advisor (rear) with Village leaders in Niger prior to a 1973 hypertension survey.

careers this diversity of interests. Three are applying combined clinical and preventive medicine training in the following areas: one in psychiatry, one in neurology, and one in cardiology. Another is a medical epidemiologist in the Office of Planning and Evaluation of the Center for Disease Control in Atlanta, Georgia; and the remaining four hold academic appointments in departments of epidemiology or preventive medicine in medical schools or schools of Public Health. Three residents are currently in training.

Continuing education is also an important goal of the department. Rounds or seminars in preventive medicine have been given in various community hospitals and a course for practitioners will be given shortly. The department participated with the Division of Social and Behavioral Studies of the University of Maryland at Baltimore (UMAB) in the organization of a series of conferences on "Human Values in Medicine".



Senior resident Paul East (center), worked with Assistant Dean Gregory Handlir (right) on a faculty survey for Dean John Dennis (left).

## SEARCH FOR CAUSES

Today the Department is heavily involved in two projects, one dealing with hypertension and another pertaining to coronary heart disease.

In the Hypertension Detection and Follow-up Program, the objective is to identify individuals with hypertension and see if they can be helped by persistent treatment. There are a number of effective drugs that lower blood pressure, and one aim of the present study is to test the effectiveness of these drugs in preventing the medical complications of hypertension.



*Dr. George Entwistle is principal investigator of the Baltimore Center of the Hypertension Detection and Follow-up Program.*

The department has been designated as one of the 14 clinical centers to participate in a cooperative study supported by the National Heart and Lung Institute. Dr. George Entwistle is principal investigator of the University of Maryland Center.

The particular objective of the program is to determine the benefits of anti-hypertensive therapy given to those with elevated blood pressure in community-based populations, including those who are asymptomatic.

The center has surveyed 35 percent of the housing units in 17 census tracts around the University of Maryland Hospital and Provident Hospital to identify hypertensive individuals between the ages of 30 and 69. Previous community surveys have shown that hypertension is more prevalent among blacks than whites.

About 1,000 hypertensive patients have been examined so far. A representative half of the patients was offered care in special clinics. The other half will receive periodic examinations from the



*To detect hypertension, neighborhood residents were visited in their homes by specially-trained research workers.*

program and day-to-day care from their regular source.

According to the plan, each of the 1,000 persons will be seen at least once a year over a five-year period. The first year of this five-year phase began in March. After five years a comparison of the course of patients will determine whether or not intensive management has diminished the mortality rate of hypertensive patients.

The other project in the Department is called *MR FIT* (Multiple Risk Factor Intervention Trial). In



*Hypertension control requires careful consideration of the daily diet. A Health Education group of patients and staff meet for lunch.*

that study the department is investigating the question: Can the death rate from coronary heart disease be reduced if people follow certain health precepts and maintain certain styles of living?



The MR FIT study at the Social Security Administration in Woodlawn carefully follows volunteers who are considered a high risk for coronary heart disease.

Also funded by the National Heart and Lung Institute, this study is trying to discover if mortality from coronary heart disease can be reduced through changes in the life-style of males who are considered high risks for heart attack but who have no clinical manifestations of this disease.

The UMAP project is one of 20 clinical centers in the country involved in the National Heart and Lung Institute study. Dr. Roger Sherwin, Associate Professor in the Department is the Project Director. Dr. Mary McDill, a Behavioral Scientist, has been looking at new ways of intervention and how they can alter the life-styles of people to help prevent disease. Dr. McDill is in charge of the intervention aspects for all of the 20 clinical centers.

The Department is developing several programs aimed at behavioral modification as a means of increasing the health and well being of certain individuals. The MR FIT study has an anti-smoking program aimed at males with a high risk for cardiovascular disease. Another facet of the program involves changing dietary habits to control weight and reduce serum cholesterol level. In the MR FIT project there are 600 study volunteers from the Social Security Administration at Woodlawn, Maryland and government agencies, who are at high risk for coronary heart disease.

#### ASSESSING THE EFFECTIVENESS OF THERAPY

The University Group Diabetes Program (UGDP) provides an excellent example of how the

pooling of observations made by individual physicians and clinics revealed a trend which could not otherwise have been recognized.

This study involved 12 clinical centers with a total of 1,027 patients. The primary objective of the UGDP was the evaluation of the efficacy of various hypoglycemic treatments in preventing vascular complications in patients with adult-onset non-insulin-dependent diabetes.

Each patient received a diet which maintained a desirable body weight and each was assigned randomly to one of the following treatments: insulin in a fixed or a variable dosage schedule, an oral hypoglycemic agent or a placebo. After a few years it became apparent that the oral hypoglycemic agents were associated with a steeply rising death rate from cardiovascular causes which soon exceeded the mortality of all other groups. This led to the termination of the use of oral hypoglycemic agents in the study.

No single clinic and certainly no single practitioner could have recognized the harmful effect of oral hypoglycemics. The pooling of observations was the key factor in assessing therapeutic effectiveness.



An evening meeting offers instruction to volunteers in the MR FIT study at Social Security.

#### DEVELOPING THE HEALTH PROFESSIONS

New approaches to health care require new forms of team work, new roles, and new ways of training. The Division of Health Services, in collaboration with the Department of Medicine, has initiated a process to convert the General Internal Medicine Clinics into a coordinated Adult Primary Health Care (health and illness) System to serve as a laboratory for coordinated education of both undergraduates and graduate students in medicine.

Dr. Spicer has accepted joint responsibilities from the chairmen of the Departments of Medicine and Social and Preventive Medicine for organizing the ambulatory patient care programs

of these departments. These include the medical component of the emergency room, the establishment of an adult screening program, and the development of primary health care teams composed of internists, primary care nurse practitioners, and clinical pharmacists. Health aides, receptionists, and data analysts as well as interdisciplinary personnel in nutrition and behavioral sciences will support the teams. The entire ambulatory medical program will be served by the diagnostic and primary health care teams.

Outreach programs of primary health care teams consisting of behavioral counselling programs, obesity clinics, anti-smoking clinics, and diabetic education and counselling clinics are now operational and will serve as a basis for undergraduate education of medical and nursing students.

The Division of Health Services is planning the implementation of comprehensive primary health care for two identifiable population: one in a community and one within the institution. The first concerns the adult population living in the area surrounding the University of Maryland.

The second program will consist of a health maintenance option for state employees under Blue Cross/Blue Shield Health Insurance. This population will not be from a specific geographic area, but would represent a different socio-economic group and follow a different health care model.

A Primary Care Nurse Practitioner Program is offered in two tracts, one for primary care nurse practitioners in the health care delivery system, and the other for School of Nursing faculty to assist in the on-going conversion of both the undergraduate and graduate curriculum.

Sixty candidates have already graduated, 11 of whom have completed the 16 month formal training and apprenticeship period and have passed the final qualifications for nurse practitioners.

In addition to examining new roles for nurses, Dr. Spicer's division is cooperating with Dean William J. Kinnard of the UMAB School of Pharmacy to emphasize the role of the clinical pharmacist in ambulatory health care delivery, both within the institution and within the community.

Coordinated interprofessional and interdisciplinary programs for the Schools of Medicine, Nursing, and Pharmacy will educate health professional students to function together as members of primary health care teams.

In developing professionals, the division aims to instill in students of other specialties a sensitivity to the philosophy and practices of the social and preventive aspects of medicine.

The Department of Social and Preventive Medicine through its Division of Education has coordinated the development of a course on "Intimate Human Behavior" together with the Departments of Medicine and Psychiatry, and the Schools of Nursing and Social Work and Community Planning addressing itself to the alleged lack of knowledge and skills of health professionals in dealing with the sexual problems of their patients. Some elective courses on the subject are already offered in the medical school, but this comprehensive course covers basic trust relationships irrespective of sexuality. Thus, parent-child and professional-client relations are included, providing a broader scope of applicability. At the same time the socially desirable aspects of sexual relationships are also emphasized. The course is one of a few on this campus in which students from different schools participate in classes together.



*The Division of Health Services is developing new roles for health professionals. An example is Nurse Practitioner Andrea Sadey, here examining a patient in the Primary Care Unit.*

#### EPILOGUE

This brief narrative of the expanding activities describes the Department's response to the changes which have occurred in the nature of the most prominent diseases, in the population, in technology, and in the aspiration of people everywhere to utilize fully the benefits of modern medicine, despite the serious constraints imposed by rising costs.

Increasingly it is necessary to examine medicine's role amidst the total fabric of society. New organizations, new professional roles and new methods of therapy need to be evolved, monitored, and evaluated. University medical centers are expected to serve as catalysts and innovators in the health care system. The Department of Social and Preventive Medicine has a pertinent role in this great enterprise.

*Ed. Note: Narrative prepared with the assistance of Carolyn G. Knight.*

Photos: Phil Szczepanski

# THEODORE McCANN DAVIS, M.D.

*John D. Young, Jr. M.D.*

Dr. Theodore McCann Davis, Faculty Gold Medal recipient in the class of 1914, died at his home in Greenville, South Carolina, on May 15, 1974, at the age of 84.

While employed by the Southern Railway as an electrical engineer in 1909, young "Tim" Davis sustained a broken leg in a train accident which resulted in his hospitalization in Knoxville. Here began his interest in the art of healing and he entered the University of Maryland Medical School in 1910. After graduating with honors, he was a resident surgeon in the University Hospital for one year before he returned to Greenville in 1915.

Dr. Davis' inquenchable scientific curiosity combined with his talents as physician and electrical engineer were to result in contributions among the most notable to urologic surgery. Dr. Maximilian Stern, in 1926, had introduced his ingenious resectoscope for sectioning tissue with high frequency electrical current under water. Dr. Davis obtained one of the instruments and a high frequency current generator on loan from the Wappler Electric Co. The capabilities of the apparatus were confirmed for removing tissue from the prostate, but there was no adequate means of coagulating bleeding vessels. In 1928, Dr. Davis modified the Stern loop electrode to permit the use of both the cutting and the coagulating currents. This development marked the advent of the modern transurethral resection.

The results of this revolutionary prostatectomy were reported by Dr. Davis at the Annual Convention of the American Medical Association in June 1931. There was considerable skepticism by urologists as well as other physicians. Besides, a sometimes bitter rivalry appeared among the few members of the field interested in developing this new technique. Following the report to the AMA, the Liebel Flarsheim Company produced the Davis-Bovie generator which was to be the prototype for modern electrosurgical units. As specified by Dr. Davis, this equipment produced a high-frequency current to section tissue and a moderate-frequency highly damped current to control bleeding with an electromagnetic switch to interchange the currents.

In addition to his practice in Greenville, Dr. Davis became chief of the Department of Prostatic Resection and Operative Cystoscopy at the Crowell Clinic in Charlotte to which he commuted every week. During the ensuing six years, he performed his transurethral prostatectomy with phenomenal success on over 2,000 patients.

A severe myocardial infarct in 1937 forced Dr. Davis to retire. The early retirement apparently delayed proper recognition of his accomplishments. Mostly through the efforts of his medical school classmate and fellow urologist, Dr. Austin H. Wood, Dr. Davis was nominated for the Alumni Gold Key and Award which he received in Davidge Hall in June 1965. He donated many of his original instruments, scientific papers, films and correspondence to the Division of Urology where they are on display. In March 1966, Dr. Davis received the coveted Valentine Medal and Award from the New York Academy of Medicine for outstanding contributions to Urology. He was a member of many professional societies and honored on many occasions locally as well as nationally.

Dr. Davis is survived by his wife, Sunie May Sloan Davis, who has expressed her appreciation that his scientific memorabilia will be preserved in his Alma Mater. Few men have had a greater beneficial impact than this illustrious alumnus on the alleviation of human ills.

*Ed. Note: Dr. Young is Professor and Head of the Division of Urology, University of Maryland Hospital.*

# A New Emphasis on Adult Primary Health Care At The University of Maryland Hospital

William S. Spicer, Jr., M.D.

When the University of Maryland alumnus returns to visit this health center, we hope that the graduate will take time to both see and discuss some of the changes which have been introduced into the health care delivery services and undergraduate and graduate education programs in the ambulatory areas.

These changes are the result of efforts over the past several years which have involved not only the School of Medicine, but also the Schools of Nursing and Pharmacy. A number of separately developed programs have been integrated in the Fall of 1974 into one Adult Primary Health Care Center activity. These programs involve striking changes in patient care services; in health professional provider roles; in the nature and format of the patient care record; and perhaps most importantly, in the educational process itself for both undergraduate and post-graduate students. When the visitor digs further beneath the surface, he will find a new type of health care data system in operation which should be of interest to him because of its implications as a prototype, designed to meet the needs generated by an important recent trend. This trend is the present and future growing involvement of outside agencies with the health care system, and, in particular, with the activities of the health professional. This data system is designed to assist present students and past graduates in maintaining the primacy of the health professional in decision-making in the health care system of the future.

Perhaps one of the greatest changes that the University of Maryland graduate will recognize, and undoubtedly welcome, is the change in goals and objectives for student and house staff education which these programs indicate. This new attitudinal set gives high priority to the education and training of primary providers of health care; to a closer and more cooperative working relationship between the University Center education system and State and local medical societies; and to a far better recognition of the importance of the role of University Center involvement in many of the problems which now face the profession.

What are some of the changes which the alumnus will see and into which his input is welcomed? The first and most obvious will be in patient health care delivery services. These changes in health care services have occurred in the area of the traditional Internal Medicine approach to the delivery of ambulatory health care. Most alumni are well aware that over the last twenty years, in response to the vast increase of medical knowledge through research, Internal Medicine has changed



*Conducting an informal audit in the Primary Care Unit, from left: Nurse practitioners Tamela Johns, Andrea Sadey and Joan Bombard, with Doctors Noel List and William S. Spicer, Jr.*

from a program which developed general internists into one which developed primarily subspecialists in a multitude of fields. As a part of this change, the ambulatory services offered have become more and more specialized. The result has been that the patient from the surrounding geographic area who attends the University of Maryland Hospital O.P.D. has frequently found himself in a variety of sub-specialty clinics in order to obtain his care, but without a "home base". Another major aspect of this change has been to considerably restrict the area of function of the internist and therefore the scope of Internal Medicine education programs. Thus, the internist over the past decades has focused more and more on the middle-aged groups and on in-patients, and has become disassociated from the health care needs of adolescents and college students, on the one hand, and the aged on the other. Office gynecology, the management of common urinary tract infections and the field of behavioral counselling for nonpsychotic emotional and abuse are some examples of problems that have been taken over by other areas.

For the past several years, the Department of Social & Preventive Medicine has been developing health care service and education programs directed toward re-establishing an adult primary care service within the University Center which could introduce "well" care and preventive services as well as provide primary care illness services for the population surrounding the Hospital. In order to achieve this goal, an adult screening

unit was developed to provide more effective management and referral of patients than could be handled in the traditional emergency room situation. Further, in July 1973, a Primary Health Care Team was instituted and began enrolling members of the ill population. At the same time, the Department of Medicine began placing more emphasis on its ambulatory services and on developing teaching and education programs which would provide both students and house staff with better preparation for the future practice of ambulatory Internal Medicine. In October 1973, the efforts of these two major departments were brought together and a new Ambulant Medical Service was formed as the basis for all adult primary health care delivery and education programs.

Thus, the entire emphasis was changed. Since July of 1973, patients have been gradually enrolled to primary care providers where they will receive the majority of their care, going to the sub-specialty clinics only when appropriate to their referral needs. This should have a very beneficial impact on the sub-specialty clinics as well, because they will be able to concentrate their efforts on true referral needs. A further impact has been the broadening of the types of services offered by the primary care providers to include primary and secondary prevention and education services. In the near future, health evaluation and behavioral counselling for the well population will be introduced. The effects of these developments are two-fold: patients will receive the full spectrum of primary care services; and students will be exposed to a more complete health care delivery system during their education.

To further expand the scope of the education and training program, the primary care group is extending outside the University Center to work in cooperation with other facilities and agencies. This Fall a cooperative program was undertaken with the new Director of the University of Maryland College Health Services at College Park, in anticipation of developing health professional education and training programs dealing with the college age population. In another important advance, the University has engaged in planning a new program under the leadership of the Medical and Chirurgical Faculty to implement improved health care delivery services for the aged. This would include the development of education and training programs as well as cost/efficiency evaluation mechanisms for this critical area of health care.

Once the visiting graduate has recognized that the emphasis has been changed from specialty clinics to primary health care delivery, both in attitude and in the physical utilization of space in the adult medical services area, the next striking change he will see is that these health services are being delivered by teams of health professionals. The major elements of these teams are physicians, primary care nurse practitioners, and clinical

pharmacists, all of whom are supported by receptionists and health aides. The University of Maryland Schools of Nursing, Medicine and Pharmacy initiated a joint program in the Fall of 1970 to develop an expanded role in nursing, particularly in ambulatory services. By 1971, a formal education and training program was underway, which by 1972 was supported by a federal contract. This Adult Primary Care Nurse Practitioner Program has graduated approximately 60 individuals from the 16-week full-time training program. The nurse who enters this program comes from a highly-selective environment against a tense competition (only one out of ten applicants is accepted). She is committed to a 16-month period of education, training and apprenticeship. She must have an identified physician preceptor with whom she will work. The course involves four months of full-time study on the University of Maryland Baltimore Campus, followed by a 12-month apprenticeship period in her sponsoring agency or institution.

The growing involvement of non-physician health professionals and paraprofessionals in the delivery of health care has brought out many different concepts of "expanded roles" for health professionals, many of which we feel are not well thought-out. Therefore, it is important to say a few words about the concepts of the Primary Care Nurse Practitioner Program, and how they differ from the others. Currently, there are three major concepts being used as the basis for various "expanded role" programs. The first is that of *providing a physician substitute*. This concept holds that, because of the shortage of doctors—particularly the shortage of primary care physicians—it is necessary to develop other types of health providers to take up the slack. The University of Maryland does not share this concept. We believe that if one wants physicians, one should educate and train physicians. There is no adequate substitute for them except in extreme circumstances, for example in a program like the Frontier Nursing Program, where vast land areas make it necessary to utilize specialty-trained nurses who remain in communication with a central physician.

The second concept is that of a *physician extender*, exemplified by most physician assistant programs. In most instances the physician extender is an individual who performs certain tasks—usually technical in nature—under the direct supervision and specific direction of a physician. By relieving the physician of these tasks, the "extender" frees him to spend more of his time on his more complex management and diagnostic efforts. The University of Maryland, after a thorough discussion, has decided it will not participate in this type of program, feeling that if there is a need for such training it should be fulfilled by other community institutions closer to the area of need.

The third concept is that of *expanded roles for other health professionals*; and it is this concept

that we endorse. Basically, this means that the quality and quantity of additional health services will be expanded by a more appropriate assignment of functions which will utilize each health professional to the maximum. The Adult Primary Care Nurse Practitioner is a classic example of this concept. The nurse practitioner functions with a physician, never as an independent provider of care. In the physician-nurse practitioner team concept, the physician maintains his leadership and is responsible for the complex diagnostic and patient management problems, as well as the overall sophisticated decision-making which goes into providing comprehensive health care. In the area of the management of chronic diseases, the PCNP interfaces with the physician, and, to a large extent, takes over this management and care. Here, it is felt that her training and background, when supplemented by further education, qualify her to perform this function as well as—or better than—a physician. In addition, there are other areas such as college health services, care of the aged, behavioral counselling and health evaluation which can be fulfilled by the *qualified* nurse practitioner.

A final word on the adult PCNP role: they are educated and trained to fulfill a function in primary care in the ambulatory area; they are not educated and trained in any concept to be an intern substitute, any more than they would be any other type of physician substitute. This program has stringent testing and qualification gates during and at the end of both the 16-week formal course and the 12-month apprenticeship period. These qualification gates are at such a high level that they will assuredly meet the needs of any potential national examinations for this group of individuals in the future. In developing this program, the University of Maryland has worked closely with the Joint Practices Committee of the Medical and Chirurgical Faculty to assure that quality of care standards are maintained.

The third professional member of the team is the clinical pharmacist. This is an individual with approximately eight years of post-secondary school education who has had additional training in the basic concepts of the diagnostic and management process of patients. He is exceedingly knowledgeable in pharmacotherapy and in his role conducts extensive education programs for all members of the team at both the under-graduate and post-graduate level, thereby having a significant impact on the utilization of pharmacotherapeutic agents in the care of patients in the ambulatory setting. It is important to remember that it is much more difficult to manage a patient under an ambulatory circumstance, where he is away from observation most of the time, than it is in an in-patient circumstance, where the patient is always present and where any problems associated with therapy are usually identified quickly. The clinical pharmacist, in addition, plays

a very important role in the medical audit for care review process, both in oral audits and in review of records. He is available as an immediate consultant on problem cases and as part of his activity establishes a competent drug information system for the providers.

As with most new programs, the best way to truly understand the function of this primary health care team is to pay a visit to the Primary Care Unit, which is located on the third floor of the North Hospital, and spend an hour or two with the team in the patient care process. The returning alumnus visiting the adult primary health care area would notice several things. He would find that patient appointments are made with the nurse practitioner. If the case is determined to be a complicated one, the patient is immediately transferred to the physician member of the group and is returned to the nurse practitioner for continuing management when stable.

The visiting physician will also note fairly rapidly that the problem-oriented medical record system is used throughout the area. We would like to make it clear that the problem-oriented record, in and of itself, is not a solution to health care problems. However, when appropriately used and appropriately audited, it becomes a very effective educational device and probably the only realistic means by which we can evaluate the data base on which our care is delivered. Obviously, a problem-oriented medical record is no one specific type of record, but is rather a basic concept with appropriate structuring of the record which should be changed to meet the needs of the population being served. For example, if one is dealing with an adult ill population, one will need one type of problem-oriented medical record format. One would obviously use a different type of format, on the other hand, when dealing with a well population, or children, or surgical cases.

One of the areas in which the physician visitor will be most interested is the audit process. Audits are conducted to achieve optimal quality of health care and to detect any deficiencies in the process so they can be remedied through the educational programs. The University of Maryland shares with the physician and nursing community at large a deep concern that all types of medical care audit and evaluation be structured in a most positive fashion, so they have a constructive educational outcome as their goal, as opposed to being considered a potentially punitive activity.

To accomplish this purpose throughout the adult primary health care delivery area, both oral and record audits are conducted. Oral audit sessions are adapted to the environment in which they occur, and are aimed at judging either the outcome of care and/or the process of care. As an example, in the adult screening area the Internal Medicine house staff members who are on duty break at approximately 4:00 every afternoon for a "peer" oral audit of the charts which have passed

through during the day. This audit involves the division of charts so that each of the three house staff members reviews the charts of his two peers. This process is supervised by a faculty "referee", who also usually picks some predominant theme of the day in order to conduct a further educational exercise. However, top priority is given to the well-being of the patient, and to assuring that the outcome of any of the actions taken that day did not in any way jeopardize the patient. Throughout the adult primary health care area, all charts are audited daily by some senior individual, who indicates the auditing process by his signature.

In the primary health care team area, audits are conducted daily over the lunch hour. They may be chart audits, they may be a review of the data base on new cases which have been worked up that day, or they may be educational process audits to cover a topic area. This latter case would arise when it has been identified that a large number of cases of a particular disease are being seen, and where it is noted that there are some significant differences in the way in which these patients are being diagnosed or managed. This is done to assure that these differences are not incompatible with good patient care.

The record audit follows the basic guidelines of the American Hospital Association, as adapted to the ambulatory area. Here random case audits by diagnosis are conducted to assure the quality of the record and the appropriateness of the entire diagnostic and management process. The ambulatory medical record audit process is supervised and directed by an audit committee made up of faculty, house staff, senior nursing personnel and clinical pharmacists. The audit committee has patient care evaluation assistants available to it, as well as a basic patient care provider and health services data system which allows the committee to identify the cases by diagnosis and to continuously monitor the patient loads in terms of diagnostic and management problems.

Another feature of the educational process is that, to the extent possible, health providers who are at different educational levels have programs which are targeted to their levels. For example, one does not attempt to mix the first or second-year residents with the medical students in a common education program. Certain programs are directed to the nurse practitioner, other programs to the senior house staff, and so on.

In viewing the entire educational process, we find that it is very important to clearly identify between two educational concepts. There is one educational concept which is appropriate to those

people who are intimately involved in the delivery of care, and who are in fact providers of care, e.g., medical house staff. On the other hand, there is a different educational concept which is appropriate for those not intimately involved with the delivery of care programs, e.g., undergraduate students.

One extremely important component of the adult primary health care center which is not readily apparent is the basic encounter data system which is ongoing. This data system obtains information on the patient, the providers and the health services offered. As a result, this information can be made available to describe not only the characteristics of the patient population being observed, but the management techniques used to care for that population. Further, it can provide basic information on the cost efficiency of various types of health providers under various types of disease circumstances.

Bringing all of this together, the alumnus who visits the adult primary health care center area will envision a primary health care team composed of the following: a faculty supervisor, a senior resident and a junior house staff member working cooperatively with six to seven primary care nurse practitioners, and a clinical pharmacist—all supported by their own receptionists and health aides. This team is providing care to a population of people who see it as their primary provider and advocate in the midst of a complicated University Hospital system. We believe that this system of delivery of care is an important model for medical, nursing and pharmacy students to have constantly in front of them. We believe that it will provide them with an example of the importance of the role of primary health providers in the health care system. Undoubtedly, this influence, with its exciting care and educational environment, will have a strong effect on the career choices of many of these individuals.

*Ed. Note: Dr. Spicer is Professor of Medicine, and Social & Preventive Medicine at the University of Maryland Medical School, and Director of Ambulant Medical Services at the University of Maryland Hospital.*

Photo: Phil Szczepanski

## A NOTE OF THANKS

The Editorial Staff of the *Bulletin* wishes to express its appreciation to Dr. Samuel S. Glick and Mr. Ross P. Campbell for their efforts and interest in providing information concerning our alumni members.

# VIRAL HEPATITIS IN PREGNANCY

John C. Hisley, M.D.

## Introduction:

Viral hepatitis is the major cause of pathologic jaundice in pregnancy. Seldom is this disease fatal. Unless viral hepatitis is epidemic or severe maternal malnutrition coexists, the prognosis for mother and fetus is good. Described in this report is the experience of University of Maryland Hospital with viral hepatitis and a literature review.

## Case Review

From 1959-72 at the University of Maryland Hospital, there were 8 cases of viral hepatitis associated with pregnancy. During this time 37,724 deliveries were performed. Patients with viral hepatitis in pregnancy varied from 17-25 years of age with a mean age of 21 years. Their parity was less than four. The disease dominated the later part of the second trimester and the entire third trimester of pregnancy. Although one infant was delivered prematurely, the fetal and maternal outcome were good. Initial complaints of those infected were nausea, vomiting, fever awareness, malaise, anorexia and in all instances dark urine. The most constant physical sign was right upper quadrant tenderness. Admission liver profiles revealed consistently elevated serum bilirubins and thymol turbidities. Bile pigments were present in all urine samples. Determinations of Australian antibodies were not performed in any of the cases reviewed.

Treatment in all instances was supportive with close observation of hepatic and renal reserve. There were no cases of hepatorenal syndrome.

## Discussion

Severe viral hepatitis in pregnancy is easily recognized. However, the differentiation between benign cholestatic jaundice which is very rare and mild viral hepatitis is very difficult. The incidence of viral hepatitis in pregnancy may well be under estimated since the symptoms of anicteric hepatitis are often misconstrued. At the University of Maryland Hospital, the incidence of viral hepatitis in pregnancy is 0.012%. In non epidemic areas an incidence range of 0.012% to 0.090% has been reported.<sup>1,2,3</sup> Referring to cumulative statistics of seven large series in the United States, Siegler reports an incidence of 0.077% or approximately one case of viral hepatitis per 1500 deliveries. Peak years have been noted in the United States in 1954 and in 1961.

At the University of Maryland Hospital patients presenting with viral hepatitis in pregnancy had a mean age of 21 years. In citing Mansel's Series, Peritz reports that the age range of patients with viral hepatitis in pregnancy is 20-24 years. There are no racial differences and an association between this disease and parity does not exist.<sup>3,4</sup>

Because of the similarity of symptoms, mild viral hepatitis is difficult to differentiate from benign physiologic jaundice of pregnancy. Few cases of subclinical viral hepatitis are discovered because of the non specificity of malaise, anorexia, nausea and vomiting. The clinical diagnosis of severe viral hepatitis is not a problem. In the University of Maryland series, all patients had a more severe form of the disease and exhibited in addition to the nonspecific symptoms mentioned, dark urine, jaundice, hepatomegaly and right upper quadrant pain. Cahill's experience echos these observations.<sup>5</sup>

The distribution of viral hepatitis during pregnancy is sporadic.<sup>5</sup> In the University of Maryland's experience, viral hepatitis was clinically manifested beginning in the latter half of the second trimester. Hsia reasons that the conjugation of bilirubin is impaired by the progestin inhibitory effect on glucuronyl transferase resulting in a prevalence of jaundice during the latter months of pregnancy.<sup>6</sup>

As uncomplicated pregnancy causes a number of changes in liver metabolism, the biochemical testing of liver function, useful in the diagnosis of viral hepatitis, requires careful interpretation. Normally, progestin interference of bilirubin conjugation does not alter serum bilirubin levels in pregnancy because the reserve capacity of the liver is very high. Sulphobromophthalien sodium is conjugated and excreted in the same manner as bilirubin. Even though its assessment is more sensitive than serum bilirubin, its reduction in conjugation after the seventh month which is associated with maximum progestin output renders this test unreliable for the evaluation of liver function.<sup>5</sup> A third trimester rise in alkaline phosphatase which seems to be related to fetal bone maturity, increase in placenta productions as well as a functional hepatic insufficiency excludes this test as a reliable index for hepatic reserve.<sup>7</sup> Even though there is a slight increase in alpha 2 globulins, total serum proteins decrease during pregnancy because of the more significant fall in serum albu-

min. False positive results in serofloccuation occur with such frequency in pregnancy that this test is not useful.<sup>8</sup> Liver histology is unchanged in pregnancy.<sup>9</sup> Apparent renal cell damage by the hepatitis virus lowers the renal threshold for bilirubin. Hence, it is not unusual to find urinary bile pigments when the serum bilirubin is normal thereby antedating clinical jaundice.<sup>3</sup> Positive thymol turbidities are consistently helpful in discovering viral hepatitis in pregnancy. However, 12% of pregnant patients can have false positive thymol turbidities.<sup>7</sup> In the University of Maryland's experience all patients had dark urine containing bile pigments, and elevated serum thymol turbidities and bilirubin. Lack of a specific test for viral hepatitis makes its preclinical detection difficult during pregnancy.

Normal uncomplicated pregnancy causes some changes in liver metabolism as evidenced by biochemical testing. One might expect pregnancy to alter the course of viral hepatitis and be associated with a high mortality than that found in the general population.<sup>3</sup> At the University of Maryland Hospital there were no maternal deaths and the course of the disease was not prolonged. In the Western literature, there is no difference in mortality between the pregnant and non pregnant population.<sup>4, 7, 10, 11</sup> A 20 fold increase in maternal mortality is reported in the Indian and Australian literature. The disease is more fulminating during pregnancy in these epidemic areas because of coexisting malnutrition.<sup>5</sup> Anemia as well as multiparity seem to be factors associated with higher mortalities.<sup>1</sup> When chronic malnutrition does not exist and when the disease is not epidemic, pregnancy does not modify the course of the disease nor does it increase the risks.<sup>1, 11, 12</sup>

Opinions vary as to the effect of viral hepatitis on the fetus. In non epidemic areas, viral hepatitis associated with pregnancy does not result in an increase in prematurity, abortions, stillborns or fetal defects.<sup>1, 5, 13</sup> When the disease occurs during the first trimester, fetal malformations have not been found.<sup>7</sup> The consensus of the Western literature is that fetal prognosis is good as viral hepatitis is rarely fulminating in adequately nourished mothers. Alleged transplacental transmission of the virus is rare as Parker was unable to identify any cases of neonatal hepatitis in his series of 75 patients.<sup>3</sup>

Very little evidence exists that any particular medical regimen influences the course of mild hepatitis. Supportive therapy should be instituted and hepatic as well as renal function should be monitored as renal failure associated with viral hepatitis has been reported.<sup>1</sup> Because infected pa-

tients are a source of cross contamination, one must isolate their excrements. Hepatotoxic drugs and anesthetics should be avoided as well as those compounds that are detoxified by the liver.<sup>2</sup> Gamma globulin does not ordinarily neutralize the virus of viral hepatitis. Patients with fulminating disease have benefited from steroids and in some instances exchange transfusion.<sup>14</sup> No untoward effects have been reported in neonates whose mother had viral hepatitis and were permitted to breast feed. As pregnancy does not alter the course of viral hepatitis in a non epidemic area where maternal nutrition is adequate, and as fetal damage has not been observed, the termination of pregnancy because of maternal viral hepatitis is not indicated.<sup>5, 7, 11, 12, 13</sup>

## Summary

The incidence of viral hepatitis during pregnancy is approximately 0.021%. As the early symptoms of this disease are non-specific, its pre-clinical diagnosis is difficult. Many liver function studies are not reliable diagnostic adjuncts. Dark urine containing bile pigments and abnormal thymol turbidity are the most consistent laboratory aides. Supportive therapy is recommended in mild cases with individualized regimens being reserved for fulminating infections. In non epidemic areas, where maternal nutrition is adequate, fetal and maternal outcome is excellent. Termination of pregnancy for maternal viral hepatitis is not recommended.

## REFERENCES

1. Douglas, J. M.: Hepatitis and Renal Failure in Pregnancy. *Arch. Internal Medicine* 122: 59-62, July, 1968.
2. Meadow, S. R.: Infectious Hepatitis and Stillbirth. *Brit. Med. J.* 1: 426, February, 1968.
3. Parker, M. L.: Hepatitis in Pregnancy. *Med. J. Australia* 2: 967-70, November, 1967.
4. Peritz, A.: Infectious Hepatitis in Pregnancy. *Obstet. Gynec.* 14: 435-41, October, 1959.
5. Cahill, K. M.: Hepatitis in Pregnancy. *Surg. Gynec. and Obstet.* 114: 545-52. May, 1962.
6. Hsia, D. Y.: Inhibition of Glucuronyl Transferase by Progestational Agents from Serum of Pregnant Woman. *Nature (London)* 187:692, 1960.
7. Ikonen, E.: Jaundice in Late Pregnancy. *Acta Obstet. Gynec. Scand. Supple 5*, 43: 1-130, 1964.
8. Ylostalo, P.: Liver Function in Hepatosis of Pregnancy and Preeclampsia. *ACTA Obstet. Gynec. Scand., Supple 4*, XLIX: 1-53, 1970.

9. Whetstone, H. I.: Liver Function During Pregnancy: Values of Certain Standard Liver Function Tests in Normal Pregnancy. Am. J. Ob-Gyn, 76: 480, 1958.
10. Deodhar, K. P.: Viral Hepatitis During Pregnancy. J. Post-grad. Medicine 17:37-42, January, 1971.
11. Sherlock, S.: Jaundice in Pregnancy. Brit. Med. Bulletin 24: 29-43, 1968.
12. Roth, L. G.: Infectious Hepatitis in Pregnancy. Am. J. Med. Sci. 225: 139-46, 1953.
13. Thorling, L.: Jaundice in Pregnancy. ACTA Med. Scand. Supple 302, 1-123, 1955.
14. Hewlett, J. F.: Viral Hepatitis, New Eng. J. Med. 288:468-9, March, 1973.
15. Combes, B.: Alterations in the Sulphobromophthalein Sodium Removal Mechanism from Blood During Normal Pregnancy. J. Clin. Invest. 42: 1431, 1963.
16. D'Cruz, I. A.: Infectious Hepatitis in Pregnancy. Ob-Gyn 31: 449-55, April, 1968.
17. Siegler, A. M., Klyser, H.: Acute Hepatitis in Pregnancy. Am. J. Obstet. Gynec. 86: 1068-73, August, 1973.
18. Samuels, B.: Jaundice in Pregnancy. Obstet. Gynec. 17: 103, 1961.

*Ed. Note: From the Department of Obstetrics and Gynecology, University of Maryland, School of Medicine, Baltimore, Maryland 21201*

**REPRINT REQUEST TO:**

**John C. Hisley, M.D.**

**Department of Obstetrics & Gynecology  
University of Maryland Hospital  
Baltimore, Maryland 21201**

---

## THE ROBERT E. LEE FILM

The Alumni Association of the Medical School gave assistance to Dr. John C. Krantz, Jr., Emeritus Professor of Pharmacology, in a project to produce a film adapted from a lecture given by Dr. Krantz on the "Implications of the Medical History of General Robert E. Lee". Dr. Benjamin M. Stein of the class of 1936 generously supplied the funds to solicit the members of the alumni for funds for this endeavor. The response of the members was very gratifying. The Alumni Association with friends of Dr. Krantz and the Maryland Division of the Daughters of the Confederacy raised approximately \$34,000 for the production of the film.

The film will be completed this autumn and will be available for showing at medical schools and medical society meetings. The endeavor was sponsored by the University of Maryland and the film may be obtained without charge from the Film Library, University of Maryland, College Park, Md. 20740. The assigned title is "R. E. Lee—His Other Battlefields". The thrust of the film is three fold:

1. The model of a Southern gentleman that was the impeccable General Lee is not an out-moded way of life for modern America.
2. The 5 or 6 diseases that plagued the General, and likely had a great influence in the outcome of the war, could have been cured and/or ameliorated through the efforts of modern medical research.
3. War is a stupid and futile means to employ in an attempt to solve the differences between nations.

I hope many of our alumni will take advantage of this opportunity to view the showing of the film.

The author wishes to thank again all the members of the alumni who contributed to the project. There were about 300 in all. I endeavored to thank each of you by mail, but this is to anyone I missed, thank you so much for your help. Also I wish to thank Col. Frank W. O'Brien and Mrs. Jean D. Goral, the former and present executive secretaries of the Alumni Association for their kindness and effort in making this project possible.

John C. Krantz, Jr.  
Gibson Island, Md. 21056

# TARGETED RESEARCH OR TARGETED DEVELOPMENT?

*Frederick J. Ramsay, Ph.D.*

There is an emergent ideology emanating from Washington whose advocates maintain that the only way in which the Nation's health problems will be solved is by the stern application of the principles of business administration to the Health Care System, including its educational and research components. The plenary sessions of the two most recent annual meetings of the American Association of Medical Colleges have been dominated by lectures on the merits of cost effectiveness, as practiced by the Department of Defense and industry and the demerits of health providers who have failed to adopt these (presumably) beneficial techniques. It follows from these warnings issued from the Federal Establishment, that there is an across the board acceptance of the notion that these techniques should be applied, that the Health Care System is comparable in this important respect to business generally and the Department of Defense specifically, and that in their self-centered pursuit of independent entrepreneurship, the Health Care Complex has been deliberately or innocently mule-headed about adopting systems of managerial efficiency.

The last assertion may or may not be true but only has relevance if the first and second statements are true. Clearly if it can be shown that only a minority subscribe to the concept and/or the two systems are not comparable it makes no difference whether or not one has been remiss. The first assertion must fall under the general heading of an untested (and probably untestable) assumption leaving the crux of the argument to the second. It is critical, at this time, that this issue be explored. The wheels of Federal fiscal planning are rolling inexorably along a path determined by the assumed truthfulness of the statement that health care is a business like any other. If it subsequently proves to be otherwise, an era of fiscal and moral crisis is eminent which may take years to resolve.

Nationalist mythology insists that America is the mighty nation it is because, first, last and always, it is practical. Americans do not expend their

resources—whether creative, material or time—in the pursuit of non-useful ends. The development of the atomic bomb through the Manhattan Project, the genius of Ford, Edison, the Wright Brothers, Salk and, back when it was fashionable, Howard Hughes, is cited in support of this thesis, while the enormous number of serendipitous discoveries stemming from non-product directed research is conveniently ignored.

Yet a careful inspection of what has occurred reveals a state of affairs amenable to a much more flattering bit of mythology. The genius of this Country is not that it is practical at the first, but that it is practical at the last—that it sees practical uses for the facts of research not that it necessarily does practical research. In short, because it is willing to expend resources on research of every variety and kind, an immense bank of information has been developed which permits the extraction of nearly limitless applications. The Country's strength, if it has one, is its ability to exploit this fund.

If one assumes that any system is the sum (at least) of its constituent parts then it follows that a demonstrated dissonance between the statement about it and a significant portion of the system under scrutiny leaves one relatively free to cast doubt on the truthfulness of the whole statement.

One major flaw in thinking of Health as a business lies in the role or place or function of basic research. The industrial approach to the production of goods and services follows at least three phases: Research, Development and Manufacture (for goods) or Programs (for services) followed by some method of profitable distribution. Applying this schemata to basic medical research requires several admissions. It must be admitted that the intent, whether explicit or implicit, of all research is ultimately to produce a useable, definable product. It must also be admitted that the next step is to be one involving the development, in a commercial sense, of the product, including such diverse considerations as cost effectiveness, profit, sales, packaging, etc., and finally it must be

admitted that academic medical centers are the appropriate arenas in which this is to take place.

Research is fundamentally an activity of mankind which is pursued as a form of secular theology. It is man's historical quest for the grail of self-explanation. It is done because it satisfies man's deep-seated need to understand his origins, his present state and predict his future. That he was also able to put his discoveries to use explains the historical accident which places him in command of his environment. To insist, by Governmental fiat, at this late date, that the process be reversed, that knowledge shall now stem from use, requires an abnegation of a pattern established over many millenia. There is some evidence, primarily in the pharmaceutical industry and the Armed Services research and development units, that targeted research\* can lead efficiently and directly to the elaboration of useful products. These programs work best, however, when those who are so employed are free to explore tangential, non-practical, lines of inquiry, when there is a large amount of background non-product research from academic research centers and from which ideas can be drawn, and when the task is the selection of alternative solutions not the creation of solutions. In short successful targeted research is largely Development—not research at all. In this light there is not a scrap of evidence to indicate that a purely utilitarian approach to research will work. Indeed some of the most frequently cited failures contributing to the threatened federal cutbacks (Regional Medical Programs, Training Grants, Health Manpower subsidies, etc.) were all designed along the pattern now suggested—none represented the practical application of previous research.

\*In the past this activity was referred to as Applied or Practical Research. The new jargon smacks uncomfortably of the pervasive linguistic influence of the Department of Defense.

One must then be very careful about succumbing to the seductively attractive proposal to diminish or eliminate the distance between the phases of research and development. To try to make them overlap is an even more delicate proposition. Research, by its creative nature, is qualitatively different from development. To assume that the same personnel can or should be involved in both is probably unwise and perhaps

impossible as it assumes for researchers in general a state of mind and intellectual capacity accorded to but a very few.

Thus, the basic research community is faced with but two choices: (1) to hold out against the trend, cut production as it were, and await happier days, or (2) to lie. It is a difficult, but not an impossible task to couch one's research protocol in product-oriented direction. The ethics of such maneuver is something else again. With the wholesale introduction of targeted research several serious questions are raised: are we to acquiesce or no; if so, to what degree, to what purpose and how will that affect the intellectual structure we have developed through history? If not, how do we next proceed; are we to succumb to an era of grant request mendacity for the sake of our research or will we simply put our research aside. And, finally, will the financial pressures that can be applied to reverse this last stand force us into some other position even less comfortable and untenable?

It is an easy thing to grant the legitimacy of applying sound business practice to the business of medical care. It is a potentially dangerous undertaking to assume that medical care is nothing but a business.

*Ed. Note: Dr. Ramsay is Associate Dean and Director of the Office of Student Affairs and acting chairman of Anatomy, University of Maryland School of Medicine.*

## THE APPLICATION OF EDUCATIONAL TECHNOLOGY IN DENTAL AND MEDICAL EDUCATION

Ernest F. Moreland, Ed. D.,



Fig. 1—Library of instructional media for independent learning

Recently, the Dental School's Division of Educational and Instructional Resources entered into a cooperative agreement with the School of Medicine to produce self-instructional programs in television. The Dental School provided the production staff and facilities and the Office of Medical Education provided content specialists, the graphic materials, and the program director. Richard J. Schnieder, M.D., Ph.D., Division of Neurosurgery, Department of Surgery, completed production of the first color videocassette produced through the cooperative agreement. His program, "The Morphology and Histology of the Muscle Spindle Organ and the Golgi Tendon Organ", is the first of a series dealing with segmental reflexes of muscular origins.

Self-instructional programs permit students to cover, by independent study, information conventionally covered in lecture, thus permitting deviation from the standard practice of education—large groups of students moving forward at the same speed, covering much the same material and reaching the same standards for promotion—geared for the "average". Those who could move faster, lose interest and waste time; those who should move more slowly, fall behind and lose interest and fail.

Although the use of self-instructional materials is relatively new to the School of Medicine, the Dental School students have had the opportunity to use self-instructional media as an integral part of their curriculum for the past four years.

Under the direction of Dr. Ernest F. Moreland, the Division of Educational and Instructional Resources has been producing media of all types, acquiring programs when local production would only be superfluous, and managing an independent learning center for students and practicing dentists. Their library of independent learning programs now totals well over 1,000, ranging from basic science materials to those demonstrating intricate clinical procedures in dentistry (Fig 1).

The Division consists of four areas: the Independent Learning Center, Television, Photography and Graphic Arts (Fig 2). Each area has distinct responsibilities in the overall program of instructional development.

The Independent Learning Center has recently been expanded to 3,200 square feet (Fig. 3). The Center provides an environment conducive to learning with wall-to-wall carpeting, an acoustically treated ceiling, and 100 carrels for individualized or small group study (Fig. 4). Self-instructional materials are available in media consisting of videocassettes (Fig. 5), 8 mm. single concept films, synchronized slide/tape programs (Fig. 6), programmed texts, filmstrips, records, patient documentation packages, audio tapes and other independent learning materials as developed within the school or purchased (Fig. 7).



Fig. 4—100 Independent study carrels with appropriate hardware to complement software

The television facility provides full color recording, transmission, and duplication of televised instruction (Fig. 8). Two floor cameras, a microscope camera and a film chain enable an instructor to carefully integrate various types of materials into each program and gain maximum benefit from a

**DIRECTOR  
Educational &  
Instructional Resources**

**Graphic  
Arts**

**Photography**

**Television**

**Independent  
Learning  
Center**

*Fig. 2—Division of Educational & Instructional Resources*

multi-media approach. Special effects are also available to emphasize selected points within a program. While a demonstration is being observed by television, students are in the laboratory performing the operations prescribed by the instructor. Additional faculty members are available in the laboratories for immediate help.

The television transmission system enables five programs to be transmitted simultaneously to approximately 100 monitors in each of 16 multidisciplinary laboratories. Lecture and conference rooms are similarly equipped. A means for talkback has been incorporated into the system, providing a means for dialogue to be carried on between an instructor in the studio and the students in any of the receiving stations.

An additional use of the television facility provides for the transmission of patient education programs into the patient waiting area, making more productive use of the patient's idle time.



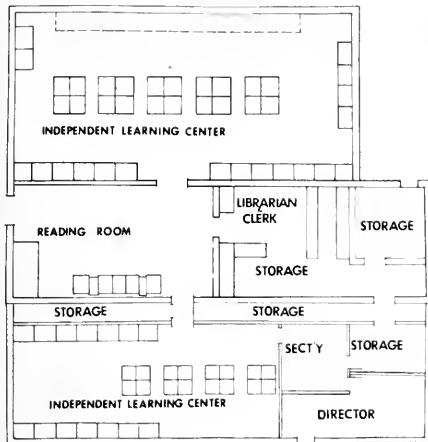
*Fig. 5—The use of videocassettes places televised instruction at the fingertips of the learner.*



*Fig. 6—Synchronized slide/tape programs*

The Division's technical and professional staff complement each other in providing the means for developing materials to meet the specific needs of the dental students and faculty. Services in this area include a vast array of visual materials—photographic prints, slides, textbook illustrations, transparencies for classroom use, independent learning programs, and materials for convention exhibits and displays.

The cooperative agreement between the Dental and Medical Schools will provide televised instruction at the fingertips of the medical students. These self-instructional materials will allow students the opportunity of checking out programs at their leisure, progressing through the material at their own rate, and viewing the information as many times as necessary to master the program objectives.



*Fig. 3—Design of Independent Learning Center.*

Ed. Note: Dr. Moreland is Interim Associate Dean for Academic Affairs and Assoc. Professor and Director Division of Educational and Instructional Resources, U. of Md. School of Dentistry.



*Fig. 7—Some programs incorporate a multimedia approach using the microscope, glass slides, color prints, and text.*



*Fig. 8—A fully-equipped color television facility provides programming to meet instructional needs where motion is a necessity.*

## NEW ALUMNI ADMINISTRATOR

The new face with the pleasant smile in the Alumni Office belongs to Jean D. Goral who has assumed the position of Executive Administrator. Prior to her employment with the Medical Alumni, Mrs. Goral had twenty-one years experience in various secretarial positions, most of which were at an executive secretarial and administrative level.

She is a native Missourian, but claims title as a "Marylander", as she has lived in the Baltimore area for the past twenty-eight years. Her husband, John, is in the sales field, and their only child, Daniel, just completed a four-year enlistment in the United States Air Force.

In an effort to update and improve the present record system in the Alumni Office, Mrs. Goral recently visited the alumni offices of Jefferson Medical College, Johns Hopkins University, and the University of Virginia. To date, there have been some changes effected in record-keeping and others will be implemented in the future. These changes were possible with the able assistance of Mrs. Sheila A. McNair, Clerical Assistant, also a new member of the Alumni staff.

Mrs. Goral emphatically states that the Alumni staff is eager to assist all members of the Associa-



**MRS. GORAL**

tion in any way possible. No inquiry or request will be ignored. She earnestly requests all members to keep the Alumni Office apprised of address changes, activities and biographical information. Further, Mrs. Goral states that the Alumni staff welcomes any comments or suggestions from members concerning alumni functions.

The Officers, Board of Directors, and *Bulletin* staff extend their best wishes to Mrs. Goral for continued success in her new role as Executive Administrator of the Medical Alumni Association.

# PRESIDENT'S MESSAGE

*Robert B. Goldstein, M.D.*

Since my last communication, several items of interest have occurred which I would like to convey to you.

Thanks to the efforts of our immediate Past President, William J. R. Dunseath, M.D., the Internal Revenue Service finally approved our application for reclassification. The classification, 501(c)(3), states that our purposes are basically of a charitable, educational and scientific nature, rather than social, as previously classified. There is no question now that all dues and contributions are tax deductible.

Plans have been formulated for a reception to be held in Atlanta, Georgia on November 18, 1974 in conjunction with the Annual Meeting of the Southern Medical Association. Details of this reunion will be forwarded to the members in the southern region. Several members of the Board of Directors plan to attend and are looking forward to seeing you in Atlanta.

Preparations for Alumni Day, May 28, 1975, are underway by the Alumni Day Committee, chaired by Herbert J. Levickas, M.D. and assisted by Raymond J. Donovan, M.D. A new site has been chosen for the banquet and the arrangements are appropriate for this memorial occasion—the 100th Anniversary of the Medical Alumni Association.

The Davidge Hall Restoration Committee's Chairman, John O. Sharrett, M.D., reports that the contract has been consummated for the initial survey of Davidge Hall. This is only the first step and after preliminary findings are reported regarding the structural work and reconstruction, we will then proceed with the actual restoration as recommended by the architects. The extent of restoration will, of course, depend on our available funds.

In order to complete this undertaking, it will require the financial support of all members. If you haven't as yet made a contribution, please give this some thought and send a check to the Alumni Association, payable to the *Davidge Hall*



*Restoration Fund.* As previously stated, this contribution is tax deductible.

The Alumni staff has been busy during the summer and fall updating the mailing lists and approximately 500 changes have been made. This may explain why some of you have received this and the previous issue of the *Bulletin* for the first time in several years. It is a time-consuming job to keep the mailing lists in proper order, but if all members will cooperate by notifying the Alumni office of any change in address, it will help them tremendously.

As stressed by the immediate Past President, we are pursuing the possibility of formation of an Advisory Committee with the hope of obtaining more widespread participation in the affairs of the Alumni. Many of you have expressed particular feelings and if any of you would be willing to serve on such a committee, we would hope to hear from you at your earliest convenience. Here is your chance to develop a real input. We anticipate contacting a number of you personally along these lines in the very near future. As a matter of fact, some of you may already have heard from us.

It is said that "business is like riding a bicycle—if you don't keep moving, you'll fall down." This also applies to your Alumni Association, and in order for us to "keep moving," it will require the participation and cooperation of all the members.

# ALUMNI CHATTER

*Nelson Handler, '72, Baltimore, Md., is presently a 3rd year resident at Johns Hopkins Hospital in Psychiatry. In May, 1974, he received his M.S. in Physiology from the University of Maryland School of Medicine. Dr. Handler was elected President of the House Staff Council at Johns Hopkins, appointed a Fellow by the American Psychiatric Association, and recently had an article accepted by the *Journal of Nervous and Mental Disease* entitled, "Lithium Responsive Hyperaldosteronism in Manic Patients." In January of 1975, Dr. Handler will be teaching a post-graduate continuing education course at Johns Hopkins Hospital entitled, "Psychodrama—Theory and Technique."*

• • •

*James G. Kane, '68, Washington, D.C., recently completed a year as Chief Medical Resident at Georgetown University Hospital. During the period of January 1, 1974 to April 1, 1974, he served as a Consultant in Medicine and Infectious Disease at the University of the West Indies, Kingston, Jamaica, under the auspices of Project Hope. Dr. Kane is presently completing his final year of an Infectious Disease Fellowship at Georgetown and will then relocate in the Northeast.*

• • •

*W. Douglas Weir, '64, Balto., Md. co-authored an article entitled "Attitudinal Grouping: A Rationale for Instructional Grouping of Medical Students," published in the *Journal of Medical Education*, August, 1974.*

• • •

*William G. Cushard, Jr., 64 Sacramento, Cal., is in private practice of Clinical Endocrinology in Sacramento. Dr. Cushard is an Assistant Clinical Professor of Medicine at the University of California, a Fellow of the American College of Physicians, and was recently elected to the Endocrine Society.*

• • •

*Merrill I. Berman, '62, Baltimore, Md., is practicing Child, Adolescent and Adult Psychiatry.*

• • •

*Carlton I. Halle, '59, Baltimore, Md., specializes in Allergy and is Chief of the Allergy Clinic of Sinai Hospital.*

*Gilbert N. Feinberg, '59, Baltimore, Md., is Assistant Clinical Professor of Ophthalmology at the University of Maryland School of Medicine and Chief of the Contact Lens Clinic at the University of Maryland Hospital.*

• • •

*Salvatore J. DeMarco III, '59, Baltimore, Md., is Chief of Surgery at the Good Samaritan Hospital and Assistant Professor of Surgery at the Johns Hopkins Hospital.*

• • •

*Richard C. Lang, '59, Baltimore, Md., is a Diplomat of the American Board of Pediatrics. He is also a Fellow in the American Academy of Pediatrics and holds appointments as Instructor in the Department of Pediatrics, University of Maryland School of Medicine and Assistant Instructor in the Department of Pediatrics at the Johns Hopkins School of Medicine.*

• • •

*Donald R. McWilliams, '59, East New Market, Md., has been in General Practice in East New Market since March, 1968. He is affiliated with the Cambridge Maryland Hospital where he is Chairman of the Cardiopulmonary Resuscitation Committee and Director of the Coronary Care Committee. Dr. McWilliams is the Mayor of East New Market (1972-75) and one of the founders of the East New Market Heritage Foundation.*

• • •

*Howard J. Rubenstein, '59, Jersey City, N.J., is the Director of the Coronary Care Unit at the Christ Hospital, Jersey City. Dr. Rubenstein is the President of the Hudson County Heart Association and a member of the Board of Directors of the American Heart Association, Hudson County Division; the American Heart Association, New Jersey Affiliate; Professional Education Subcommittee of the American Heart Association, Upper Mid-Atlantic Region; and the American College of Physicians. He is a member of the Board of Directors of the Jersey City Boys Club and the Hudson County Boy Scouts.*

*Hans R. Wilhelmsen*, '59, Baltimore, Md., is Assistant Professor of Surgery at the University of Maryland School of Medicine and Chief of the Division of Plastic Surgery at Kernan, St. Joseph's and Maryland General Hospitals in Baltimore. Dr. Wilhelmsen is Chairman of the Cleft Palate Clinic at Kernan and a consultant for Montebello State Hospital and the Division of Crippled Children of the State of Maryland.

• • •

*Beverly J. Stump*, '59, Randallstown, Md., is the Director of Medical Care Health Services, Harford County Health Department, Bel Air, Maryland. Dr. Stump is married to another alumnus, *Harvey M. Solomon*, '59, who is an Assistant Professor of Laboratory Medicine at the Johns Hopkins Hospital. They are the parents of three children.

• • •

*Joseph Nataro*, '59, Mineola, N.Y., is Associate Director of Pathology at the Nassau Hospital of Mineola.

• • •

*Ferdinand Mainolfi*, '59, Baltimore, Md., practices Industrial Medicine.

• • •

*Karl M. Green*, '59, Westminster, Md., practices Pediatrics in that city.

• • •

*Mathew Lee*, '56, New York, N.Y., has been appointed Clinical Professor of Special Care at the College of Dentistry at the Brookdale Dental Center of New York University. Dr. Lee is Professor of Clinical Rehabilitation Medicine at the School of Medicine of New York University, and the Director of the Department of Rehabilitation Medicine at Goldwater Memorial Hospital in New York. He has taken a prominent role in the development of acupuncture along scientific lines, and has put particular emphasis on its application in dental care. Dr. Lee is the author of a large number of publications, including the co-editorship of the recent text, *Dentistry for the Special Patient: The Aged, Chronically Ill and Handicapped*.

*Marshall Franklin*, '56, Norwalk, Conn., was the guest speaker at Save-A-Heart Dinner & Art Festival held in Baltimore in September. He is the Director of the Cardiac Catheterization Laboratory and of Cardiac Rehabilitation and Associate Director of Cardiology at the Norwalk Hospital. A Diplomat of the American Board of Internal Medicine and a lecturer in Cardiology at Mt. Sinai Hospital & Medical Center in New York, Dr. Franklin recently co-authored a book entitled "The Heart Doctor's Heart Handbook."

• • •

*Nathan Schnaper*, '49, Baltimore, Md., recently authored an article entitled, "Management of the Dying Patient and His Family", published by MSS Information Corp.

• • •

*Robert C. Waltz*, '47, Euclid, Ohio, has been promoted to Assistant Clinical Professor of Surgery, Case Western Reserve University. He is also the Chairman of the Ohio Committee on Trauma of the American College of Surgeons and Chairman of the Emergency Medical Service Council, Metropolitan Health Planning Corporation, Cleveland (one of the recipients of the Johnson Foundation Grants).

• • •

*Edmund G. Beacham*, '40, Baltimore, Md., Class Captain 1975 Alumni Day Programs, was decorated with the Medal of The Legion of Merit 28 August 1974 upon his retirement from the United States Army and completion of 35 years of continuous service with the Maryland National Guard. Dr. Beacham joined the Guard in 1939 as a private, was commissioned as a Medical Officer in 1940 and was Division Surgeon of the 29th Infantry Division during World War II. He was promoted to Colonel in 1956; in 1969 graduated from the Army Command and General Staff College; and in 1972 graduated from the Industrial College of the Armed Forces. He has been State Surgeon of the Maryland Army National Guard since 1966.

• • •

*H. Leonard Warres*, '38, Baltimore, Md., served as a volunteer radiologist and teacher in Afghanistan under Medico last fall (1973). He is presently Chief of Radiology at Baltimore County General Hospital.

# Faculty News

## New Appointments

## Promotions, and Resignations

Joanne C. Rector, M.S.W., Instructor — PEDIATRICS (appointment effective 6-2-74) 2299 Sycamore Road, York, Pa. 17404; 717-764-6494.

David C. Baker, M.S., Instructor — PATHOLOGY, MEDICAL TECHNOLOGY (appointment effective 8-1-74) 17-D Queen Tree Court, Baltimore, Maryland 21207.

Murray Kappelman, M.D., Professor — PEDIATRICS (promotion effective 7-1-74) 2124 Western Run Drive, Baltimore, Maryland 21209; 367-7075.

Frances J. Fitch, Associate — PSYCHIATRY (appointment effective 7-1-74) 3936 Cloverhill Road, Baltimore, Maryland 21218; 467-7849.

Mohammad Khodabandelou, M.D., Instructor — PEDIATRICS (appointment effective 7-1-74) address not available yet.

Michael J. Murphy, Research Associate — CELL BIOLOGY & PHARMACOLOGY (appointment effective 8-15-74) 12 H Fitzgerald Court, Baltimore, Maryland 21234.

William P. Tong, Research Associate — CELL BIOLOGY & PHARMACOLOGY (appointment effective 9-10-74) 3421 Tulane Drive, Hyattsville, Maryland; 422-4803.

Jitendra Mehta, Ph.D., Research Associate — CELL BIOLOGY & PHARMACOLOGY (appointment effective 8-15-74) 5921-L Radcliffe Avenue, Baltimore, Maryland 21206; 488-5939.

Richard W. Ainsley, Research Associate — INTERNATIONAL MEDICINE (appointment effective 9-1-74) address not available yet.

Toshihide Sato, Research Associate — PATHOLOGY (appointment effective 8-1-74) % Dr. Ueda, 1629 Jeffers Road, Towson, Maryland; 828-9146.

Oscar A. Iseri, M.D., Professor — PATHOLOGY (appointment effective 7-1-74) address not available yet.

Richard H. Anderson, M.D., Clinical Instructor — PSYCHIATRY (promotion effective 7-1-74) 1604 Jeffers Road; Baltimore, Maryland 21204; 823-8651.

Robert C. Irwin, M.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 101 Forest Drive, Baltimore, Maryland 21228; 744-4757.

Thomas J. Kenny, Ph.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) Route 7—Greenspring Avenue, Baltimore, Maryland 21208; 484-6123.

H. David Kerr, M.D., Associate Professor — MEDICINE (promotion effective 7-1-74) 12807 Keswick Lane, Bowie, Maryland 20715; 1-464-2051.

Edward E. Maher, M.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 10 Seminole Avenue, Catonsville, Maryland 21228; 747-2758.

Joseph A. Mead, Jr., Professor — MEDICINE (promotion effective 7-1-74) 10703 Rain Dream Hill, Columbia, Maryland 21044; 730-3274.

Andrew J. Saladino, M.D., Associate Professor — PATHOLOGY (promotion effective 7-1-74) 11 St. Michael's Way, Baltimore, Maryland 21212; 377-0243.

Barry A. Weavers, Research Associate — PATHOLOGY (appointment effective 5-30-74) 11 St. Michael's Way, Baltimore, Maryland 21212.

Sophia Balis, D.D.S., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 1146 Gypsy Lane East, Baltimore, Maryland 21204; 823-8317

Robert D. Brodell, M.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 856 Camden Avenue, Cumberland, Maryland 21502; 724-7616.

Charlotte Ferencz, M.P.H., Professor — SOCIAL & PREVENTIVE MEDICINE (promotion effective 7-1-74) 1207 Robin Hood Circle; Towson, Maryland 21204.

Wilson L. Grubb, M.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 3607 Greenway, Baltimore, Maryland 21218; 366-6100.

Thomas B. Hubbard, Jr., M.D., Professor — SURGERY (promotion effective 7-1-74) Golf Course Road, Garrison, Maryland 21055; 363-0215.

Seung H. Chang, M.S., Instructor — PATHOLOGY (promotion effective 7-1-74) 108 Comet Court; Baltimore, Maryland 21234; 296-8967.

Begenisich, Theodore B., Associate in Biophysics — resigned 8-31-74.

Virginia Huffer, M.D., Professor—PSYCHIATRY (promotion effective 7-1-74) 5708 Kenmore Road; Baltimore, Maryland 21210; 323-3380.

Enrico Bucci, M.D., Ph.D., Professor — BIOCHEMISTRY (promotion effective 7-1-74) 5210 Tilbury Way; Baltimore, Maryland 21212; 433-7896.

Lindsay W. Black, Ph.D., Associate Professor — BIOCHEMISTRY (promotion effective 7-1-74) 2257 Rogene Drive; Baltimore, Maryland 21209; 358-4721.

Raymond B. Nagle, M.D., Associate Professor — PATHOLOGY (promotion effective 7-1-74) 10201 Parkwood Drive; Kensington, Maryland; 531-6341.

Edward C. Knoblock, Col., M.S., Associate Professor — PATHOLOGY (promotion effective 7-1-74) 12002 Greenleaf Avenue; Potomac, Maryland 20854; 424-5558.

Ruth Ellen Burger, Ph.D., Professor — PATHOLOGY (promotion effective 7-1-74) 10637 Greenmountain Circle; Columbia, Maryland; 997-0163.

Elizabeth S. Hill, B.S., Instructor — PATHOLOGY (appointment effective 7-1-74) 101 Severn River Road; Severna Park, Maryland 21145; 647-4272.

Charles Abzug, Ph.D., Assistant Professor — PHYSIOLOGY (appointment effective 9-1-74) address not available yet.

Ruth Suzanne Ashman, M.D., Instructor — PEDIATRICS (appointment effective 7-1-74) 7206 Denberg Road; Baltimore, Maryland 21209; 484-0419.

Amin N. Jurf, Ph.D., Associate Professor — PHYSICAL THERAPY (promotion effective 7-1-74) 4611 Briarclift Road; Baltimore, Maryland 21229; 566-5009.

David A. Billings, Jr., B.S., Instructor — PATHOLOGY (change of status to full-time effective 7-1-74) 4918 Clifton Ave; Baltimore Maryland 21207; 448-3334.

Wisit Boonumsiriky, M.D., Clinical Associate Physician — M.I.E.M. (appointment effective 7-1-74) 158 Stonecroft Road; Baltimore, Maryland 21229; 525-3452.

Kiyoshi Chinen, M.D., Instructor—ANESTHESIOLOGY (M.I.E.M.) (appointment effective 7-1-74) 458 Glen Mar Road, Apt. C-2; Glen Burnie, Maryland 21061; 761-7337.

Michael S. Forbes, Ph.D., Instructor — NEUROLOGY (appointment effective 8-1-74) address not available yet.

Sandra A. Forman, Research Associate — PREVENTIVE MEDICINE (appointment effective 7-1-74) 6 Montaigne Court; Pikesville, Maryland 21208; 653-9144.

Gerald T. Gilmore, M.D., Instructor — RADIOLogy (appointment effective 7-1-74) 511 Crosby Road; Baltimore, Maryland 21228; 788-7517.

Glenda Goldman, M.S., M.T., Instructor—PATHOLOGY (appointment effective 7-1-74) 2209 Rogene Drive; Baltimore, Maryland 21209; 235-7490.

Lyle W. Horn, Ph.D., Assistant Professor — PHYSIOLOGY (appointment effective 9-1-74) 230 Stony Run Lane, Apt. 2F; Baltimore, Maryland 21207.

Hans E. Kaiser, Ph.D., Research Associate — PATHOLOGY (appointment effective 7-1-74) 433 South West Drive; Silver Spring, Maryland 20901; 593-4260.

Michael J. O'Connell, M.D., Assistant Professor—MEDICINE (appointment effective 7-1-74) 2207 Sulgrave Avenue; Baltimore, Maryland; 367-8332.

Louis O. Olsen, M.D., Instructor — FAMILY MEDICINE (appointment effective 7-15-74) 1308 McPherson Court; Lutherville, Maryland 21093; 825-5252.

Charles Savage, M.D., Professor — PSYCHIATRY (promotion effective 7-1-74) 307 Clopton Hill; Sherwood Forest, Maryland 21405; 841-6307.

Ulgan I. Sila, M.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 1801 Indian Head Road; Baltimore, Maryland 21204; 828-0444.

John P. Williams, Jr., M.D., Associate Professor — RADIOLOGY (promotion effective 7-1-74) 381 Stonehouse Drive; Severna Park, Maryland 21146; 647-9278.

William S. Spicer, Jr., M.D., Professor — MEDICINE & SOCIAL AND PREVENTIVE MEDICINE (promotion effective 7-1-74) 11 Buchanan Road; Baltimore, Maryland 21212; 377-7184.

Misbah Khan, M.B., B.S., M.P.H., Associate Professor — PEDIATRICS (promotion effective 7-1-74) 2 Hadley Square, North; Baltimore, Maryland 21218; 366-1990.

**Stephen C. Schimpff, M.D., Assistant Professor — MEDICINE** (appointment effective 7-1-74) 5013 Hesperus Drive; Columbia, Maryland 21044; 997-1854.

**Robert J. Esterhay, Jr., M.D., Assistant Professor — MEDICINE** (promotion effective 7-1-74) 2215 Sulgrave Avenue; Baltimore, Maryland 21209; 466-9361.

**Thomas Kenny, M.D., Assistant Professor — PSYCHIATRY** (appointment effective 7-1-74) Rt. 7 Greenspring Avenue; Pikesville, Maryland 21208; 484-6123.

**Stanley P. Laucks, M.D., Assistant Professor — PSYCHIATRY** (appointment effective 7-1-74) R.D. #1, Dallastown, Pennsylvania 17313; 717-244-5945.

**Rudolph Bauer, M.D., Assistant Professor — PSYCHIATRY** (appointment effective 7-1-74) 5345 Harper's Farm; Columbia, Maryland; 997-2249.

**Gerald Klebanoff, M.D., Associate Professor — SURGERY** (appointment effective 3-1-74) 10937 Wickshire Way; Rockville, Maryland 20852.

**Mark M. Applefeld, M.D., Instructor — MEDICINE** (appointment effective 7-1-74) 209 Nottingham Hill; Sherwood Forest, Maryland 21405; 528-5755.

**Milton Horwitz, M.D., Assistant Professor — SURGERY** (appointment effective 7-1-74) address not available yet.

**B. Joseph Bronushas, M.D., Assistant Professor — FAMILY MEDICINE** (change of status to geographic full-time) 671 Rosalie Avenue; Route #1; Baltimore, Maryland 21221; 687-3295.

**Peter H. Wiernik, M.D., Associate Professor — MEDICINE** (promotion effective 7-1-74) 5026 Round Tower Place; Columbia, Maryland 21044; 730-6979.

**Irving D. Wolfe, M.D., Instructor — MEDICINE** (appointment effective 7-1-74) 6812 Maple Leaf Court; Apt. T-2; Baltimore, Maryland 21209; 484-7586.

**Patricia Dischinger, Ph.D., Instructor — SOCIAL & PREVENTIVE MEDICINE** (appointment effective 7-15-74) address not available yet.

**John E. Rash, Ph.D., Assistant Professor — CELL BIOLOGY AND PHARMACOLOGY** (appointment effective 7-1-74) no address available yet.

**Recep Erol, M.D., Fellow — MEDICINE** (appointment effective 7-1-74) address not available yet.

**Homer C. House, M.D., Assistant Professor — SURGERY** (appointment effective 7-1-74) 106 St. Dunstans Road; Baltimore, Maryland 21212; 433-5678.

**Father Denis J. Madden, Ph.D., Instructor — PSYCHIATRY** (appointment effective 7-1-74) 31 N. Fulton Avenue; Baltimore, Maryland 21223; 947-1242.

**Abu N. Fakhruzzaman, M.B.B.S., Assistant Professor — PATHOLOGY** (promotion effective 7-1-74) 2523 Gatehouse Drive; Baltimore, Maryland 21207; 448-2712.

**Celeste L. Woodward, M.D., Fellow — MEDICINE** (appointment effective 7-1-74) 209 Nottingham Hill; Sherwood Forest, Maryland 21405.

**Susan R. Guarnieri, M.P.H., Instructor — PEDIATRICS** (appointment effective 7-1-74) 6222 Woodcrest Avenue; Baltimore, Maryland 21209; 764-9161.

**Sharon L. Hansen, B.S., Research Associate — MEDICINE** (appointment effective 7-1-74) 1543 Kennewick Road; Baltimore, Maryland 21218; 467-0893.

**Meyer R. Heyman, M.D., Associate — MEDICINE** (appointment effective 7-1-74) 6810 Maple Leaf Court, T-2; Baltimore, Maryland 21209; 484-9128.

**Felix L. Kaufman, Instructor — PEDIATRICS** (appointment effective 7-1-74) 5-7 Slade Avenue; Baltimore, Maryland 21208; 486-6968.

**Henry C. Nipper, Assistant Professor — PATHOLOGY** (promotion effective 7-1-74) 5871 Cherrywood Lane, Apt. 302; Greenbelt, Maryland 20770; 474-3631.

**Paul Chang, M.D., Instructor — MEDICINE** (appointment effective 7-1-74) 6011 Hunt Ridge Road; Baltimore, Maryland 21210; 377-0305.

**Barry J. Schlossberg, M.D., Instructor — MEDICINE** (appointment effective 7-1-74) 4609 Horizon Circle; Pikesville, Maryland 21208; 922-0681.

**Carmen A. Fratto, M.D., Assistant Professor — MEDICINE** (promotion effective 7-1-74) 407 Westside Blvd.; Catonsville, Maryland 21228; 744-6741.

**George Silverton, M.D., Instructor — RADIOLOGY** (appointment effective 5-1-74) 2 Palmer Green; Village of Cross Keys; Baltimore, Maryland 21210; 532-7389.

Juan Luis Granados, M.D., Assistant Professor — OBSTETRICS/GYNECOLOGY (promotion effective 7-1-74) 305 Limestone Valley Drive, Apt. F; Cockeysville, Maryland 21030; 528-6030.

Henry Troutman Harbin, M.D., Instructor — PSYCHIATRY (appointment effective 7-1-74) 233 W. Lafayette Avenue; Baltimore, Maryland 21217; 225-0464.

Ramesh Khurana, M.B., B.S., Instructor — NEUROLOGY (appointment effective 7-1-74) 10549 C 2 Cross Fox; Twin Rivers Road; Columbia, Maryland 21044; 730-6469.

Sau Yee A. Shu, M.B., B.S., Instructor — PATHOLOGY (appointment effective 7-1-74) 8608 Bramble Lane; Apartment 102; Randallstown, Maryland 21133.

Peter J. Coleman, M.D., Clinical Instructor — PSYCHIATRY (appointment effective 9-1-74) 2409 Ken Oak Road; Baltimore, Maryland 21709; 664-7472.

Sara Ann Spangler, Assistant — PEDIATRICS (appointment effective 4-21-74) 209 E. 33rd Street; Baltimore, Maryland 21218.

William K. Reisen, Ph.D., Research Associate — INSTITUTE OF INTERNATIONAL HEALTH (appointment effective 6-1-74) 36 Silverwhite Road; Little Silver, New Jersey (parents' address)

Ralph Updike, M.D., Instructor — MEDICINE (appointment effective 3-1-74) 9316 Rock Meadow Drive; Ellicott City, Maryland 21043.

Murtadha S. H. Al-Marashi, M.D., Clinical Instructor — NEUROLOGY (appointment effective 5-1-74) Building #44; 485 Mount Wilson Lane; Mount Wilson, Maryland 21112; 653-1980.

Donna M. Burow, Research Programmer — SOCIAL & PREVENTIVE MEDICINE (appointment effective 4-28-74) 6400 Loch Raven Blvd.; Baltimore, Maryland 21239; 532-9787.

Wendy Maters, S.R.N., Instructor — PSYCHIATRY (promotion effective 7-1-74) 1659 Burnwood Road; Baltimore, Maryland 21239; 433-0204.

Judith Page Clark, B.A., Research Programmer — SOCIAL & PREVENTIVE MEDICINE (appointment effective 5-6-74) 1627 Shadyside Road; Baltimore, Maryland 21218; 889-2308.

Arthur M. Wagner, M.D., Instructor — NEUROLOGY (appointment effective 7-1-74) 1509 Bolton Street; Baltimore, Maryland 21217; 523-8753.

Cloe M. Sojit, Research Consultant — PSYCHIATRY (appointment effective 1-18-74) 5101 Moorland Lane; Bethesda, Maryland 20014; 657-3401.

Robert D. Frieman, M.D., Clinical Assistant Professor — PSYCHIATRY (promotion effective 7-1-74) 6724-F Townbrook Drive; Baltimore, Maryland 21207; 944-0476.

Junichiro Kawamura, M.D., Visiting Assistant Professor — NEUROLOGY (appointment effective 6-1-74) Room 1520 Sutton Place; 1111 Park Avenue; Baltimore, Maryland 21201; 225-0753.

Ernesto A. Hipolito, M.D., Instructor — ANESTHESIOLOGY (appointment effective 6-1-74) 1305 Margarette Avenue; Baltimore, Maryland 21204; 828-9080.

Yung M. Lee, M.D., Instructor — ANESTHESIOLOGY (appointment effective 7-1-74) address not available yet.

Florette T. Lee, M.D., Instructor — ANESTHESIOLOGY (appointment effective 7-1-74) 27-H Montrose Manor Court; Baltimore, Maryland 21228; 788-2774.

Charles J. Lancelotta, M.D., Instructor — SURGERY (appointment effective 7-1-74) 321 Small Court; Baltimore, Maryland 21228; 744-1357.

David M. Cook, M.D., Instructor — SURGERY (appointment effective 7-1-74) Apt. 14A; 500 W. University Pkwy.; Baltimore, Maryland 21210; 467-7081.

Denise Eby, Ph.D. (Sister), Research Associate — BIOCHEMISTRY (appointment effective 5-19-74) St. Agnes Hospital; 900 Caton Avenue; Baltimore, Maryland 21229; 644-8000.

Sharon B. Satterfield, M.D., Instructor — PSYCHIATRY (promotion effective 7-1-74) 1406 Berwick Road; Ruxton, Maryland 21204.

Mary Teresa Blair Klimovitz, Research Assistant — PEDIATRICS (appointment effective 4-28-74) 205 East Susquehanna Avenue; Towson, Maryland 21204; 821-7818.

Daniel Weinreich, Ph.D., Assistant Professor — CELL BIOLOGY & PHARMACOLOGY (appointment effective 6-15-74) 6821 Bonnyridge Drive; Baltimore, Maryland 21209; 484-8984.

Michael J. O'Connell, M.D., Assistant Professor — MEDICINE (appointment effective 7-1-74) 2207 Sulgrave Avenue; Baltimore, Maryland; 367-8332.

Craig E. Duncan, M.D., Clinical Instructor — PATHOLOGY (appointment effective 11-1-73) 19 E. Montrose Manor Court; Baltimore, Maryland 21228; 788-2650.

Mhairi G. MacDonald, MRCP, Attending Physician — PEDIATRICS (appointment effective 3-18-74) 4304 Norwood Road; Baltimore, Maryland 21218; 889-2694.

Frederick C. Kauffman, Ph.D., Associate Professor — CELL BIOLOGY & PHARMACOLOGY (appointment effective 6-1-74) address not available yet.

Raymond T. Jones, M.S., Instructor — PATHOLOGY — (promotion effective 7-1-74) 8892 B. Town & Country Blvd.; Baltimore, Maryland 21043; 465-7891.

David E. Hinton, Ph.D., Instructor — PATHOLOGY (promotion effective 7-1-74) 68 King Henry Circle; Baltimore, Maryland 21237; 391-5723.

Barbara Williams Hudson, M.D., Associate Professor — PEDIATRICS (promotion effective 7-1-74) Box 319, Windsor Mill Road Ext., Baltimore, Maryland 21207; 922-6532.

Joseph Aisner, M.D., Instructor — MEDICINE (appointment effective 7-1-74) 8216 Thornton Road; Ruxton, Maryland 21204; 296-2399.

Richard J. Kolker, M.D., Clinical Instructor — OPHTHALMOLOGY (appointment effective 7-1-74) 110 W. 39th Street; Apt. 309; Baltimore, Maryland 21210; 243-0632.

Earle M. Schulz, Jr., D.D.S., M.S., Consultant — PEDIATRICS (C.P.C.) (appointment effective 5-20-74) 6306 Leafy Screen; Columbia, Maryland 21045; 997-3294.

Charles Irving Weiner, M.D., Instructor — RADIOLOGY (appointment effective 7-1-74) 906 Smoke Tree Road; Baltimore, Maryland 21208; 484-6035.

Charles L. Weldon, Associate — PSYCHIATRY (appointment effective 7-1-74) 5436 Jonquil Avenue; Baltimore, Maryland 21215.

Froma Beth Rosen, M.S., Research Programmer — SOCIAL & PREVENTIVE MEDICINE (appointment effective 6-19-74) 3407 W. Strathmore Avenue; Baltimore, Maryland 21215; 358-2647.

Lucille Ann Mostello, M.D., Instructor — ANESTHESIOLOGY (appointment effective 8-15-74) address not available yet.

Charles A. Schiffer, M.D., Assistant Professor — MEDICINE (appointment effective 7-1-74) 2 Cross Keys Road; Baltimore, Maryland 21210; 323-4827.

Gerald J. Hunt, Ph.D., Associate Professor — PSYCHIATRY (promotion effective 7-1-74) 1506 Bolton Street; Baltimore, Maryland 21217; 669-3815.

Irving D. Wolfe, M.D., Instructor — MEDICINE (appointment effective 7-1-74) 6812 Maple Leaf Court; Apt. T-2; Baltimore, Maryland 21209; 484-7586.

Dee Zlatich, M.S., Psychology Intern — PEDIATRICS (appointment effective 7-1-74) 100 W. University Pkwy.; Baltimore, Maryland 21210.

Diane R. Ewing, M.A., Psychology Intern — PEDIATRICS (appointment effective 7-1-74) 327-3A Homeland Southway; Baltimore, Maryland 21212; 323-3319.

Yih-Min B. Huang, Ph.D., Associate — SOCIAL AND PREVENTIVE MEDICINE (appointment effective 7-1-74) 600 Wyndhurst Avenue; Baltimore, Maryland 21210; 528-7860.

Katherine E. Reuter, Ph.D., Psychology Intern — PEDIATRICS (appointment effective 7-1-74) 13908 Castle Blvd. Apt. T-1; Silver Spring, Maryland 20904.

Charles Assad, B. S., Psychology Intern — PEDIATRICS (appointment effective 7-1-74) 3811 B. Dunsmuir Circle; Baltimore, Maryland.

Thomasine Guberski, Instructor — SOCIAL & PREVENTIVE MEDICINE (appointment effective 7-1-74) 62 Acorn Circle; Towson, Maryland 21204; 828-0030.

Rustu E. Onur, M.D., Ph.D., Research Associate — CELL BIOLOGY & PHARMACOLOGY (appointment effective 7-1-74) 3613 A. Callaway Avenue; Baltimore, Maryland 21215.

Luis E. Rivera, M.D., Instructor — MEDICINE (appointment effective 7-1-74) 2423 Eastridge Road; Timonium, Maryland 21093; 252-6598.

Richard L. Violand, Jr., B.S., Instructor — PHYSICAL THERAPY (appointment effective 7-8-74) 3600 Yolando Road; Baltimore, Maryland 21218; 833-8230.

Dennis W. Shermeta, M.D., Assistant Professor — SURGERY (appointment effective 7-1-74) 1906 W. Northern Parkway; Baltimore, Maryland; 466-8855.

Theodore B. Begenisich, Ph.D., Associate — BIOPHYSICS (promotion effective 7-1-74) 6133 St. Regis Road; Baltimore, Maryland 21206; 866-1810.

J. James Tildon, Ph.D., Professor — PEDIATRICS (promotion effective 7-1-74) 5902 Cross Country Blvd., Apt. D; Baltimore, Maryland 21215; 578-8681.

Richard F. Morton, M.B.B.S., M.P.H., Associate Professor — SOCIAL & PREVENTIVE MEDICINE (promotion effective 7-1-74) 5604 St. Albans Way; Baltimore, Maryland 21212; 323-5136.

Stephen R. Max, Ph.D., Associate Professor — NEUROLOGY (promotion effective 7-1-74) 110 West 39th Street; Apt. 1002; Baltimore, Maryland 21210; 235-1426.

Luis G. Martin, M.D., Associate Professor — MEDICINE (promotion effective 7-1-74) 3206 Old Fence Road; Ellicott City, Maryland 21043; 465-3635.

John R. Lion, M.D., Associate Professor — PSYCHIATRY (promotion effective 7-1-74) 3303 Fallstaff Road; Baltimore, Maryland 21215; 358-4204.

Nathan Schnaper, M.D., Professor — PSYCHIATRY (promotion effective 7-1-74) 2401 Sylvale Road; Baltimore, Maryland 21209; 486-2273.

Albert Shapiro, M.D., Professor — MEDICINE (promotion effective 7-1-74) 3523 Baron Oaks Road; Pikesville, Maryland 21208; 486-8971.

#### RESIGNATIONS, ETC.

Geiseler, Peter Jan, Associate — MEDICINE — resigned 6-30-74.

Soterakis, Jack, Fellow — MEDICINE — resigned 6-30-74.

Weckesser, Barry J., Fellow — MEDICINE — resigned 6-30-74.

Robert G. Harper, Instructor — PEDIATRICS — resigned 6-30-74.

O'Donnell, Patricia A., Assistant Instructor in Neurology — resigned 8-30-74.

Gordon, Marvin, Fellow — MEDICINE — resigned 6-30-74.

Gilman, Priscilla, M.D., Assistant Professor — PEDIATRICS — resigned 5-18-74.

Mann, David, Ph.D., Associate — PHYSIOLOGY — resigned 8-31-73.

Flerko, Bela, Professor — PHYSIOLOGY — resigned 7-14-73.

McMillan, James J., Assistant — MEDICINE — resigned 4-21-74.

Huffman, Leroy J., Assistant — MEDICINE — resigned 5-27-74.

Daston, Anthony, Research Assistant — PSYCHIATRY — resigned 6-30-74.

Gutterman, Lorence A., M.D., Assistant Professor — MEDICINE — resigned

Pleticka, Sylvia Anna, Research Associate — MEDICINE — resigned.

Plotnick, Gary, Instructor — MEDICINE — resigned.

Spurling, Carroll L., Associate Professor — MEDICINE & PATHOLOGY — resigned.

Winter, Stephen L., Instructor — MEDICINE — resigned.

Doughty, Raleigh E., Research Assistant — MEDICINE — terminated.

Whiting, Heather E., Fellow — CELL BIOLOGY & PHARMACOLOGY — resigned 5-31-74.

Sanwalani, Shandar C., Assistant Professor — RADIOLOGY — resigned 3-74.

Nyman, Gary W., Instructor — PSYCHIATRY — resigned 6-30-74.

Jacobs, David R., Jr., Assistant Professor — SOCIAL & PREVENTIVE MEDICINE — resigned 6-7-74.

Wassif, Anis, Instructor — ANESTHESIOLOGY — resigned 6-30-74.

Logerfo, Frank W., Assistant Professor — SURGERY — resigned 6-30-74.

Liu, Helen H. C. (Mrs.), Research Assistant — PATHOLOGY — resigned 5-31-74.

Rozear, Marvin, Assistant Professor — NEUROLOGY — resigned 6-30-74.

Farag, Kameel F., Fellow — MEDICINE — resigned 6-30-74.

Geckler, Ronald W., Fellow — MEDICINE — resigned 6-30-74.

Hardegen, Gary L., Assistant — MEDICINE — resigned 6-30-74.

Irani, Rustum, Fellow — MEDICINE — resigned 6-30-74.

Kndl, Louis C., Fellow — MEDICINE — resigned 6-30-74.

Klimt, Claudio R., Assistant — MEDICINE — resigned 6-30-74.

Wizenberg, Morris J., Professor in Radiology — resigned 8-31-74.

Kawamura, Junichiro, Assistant Professor in Neurology — resigned 8-31-74.

Madarang, Alfonso, Instructor in Anesthesiology — resigned 9-30-74.

Neptune, Edgar M., Professor — SURGERY, deceased 7-27-74.

Miller, Roger M., Assistant Professor — SURGERY, resigned.

Kluge, Ronica M., Assistant Professor — MEDICINE, resigned 8-2-74.

Latimer, Ruth M., Associate Professor — PHYSICAL THERAPY, leave of absence — 1 year.

O'Morchoe, Charles C.C., Professor — ANATOMY, resigned 9-1-74.

O'Morchoe, Jean, Assistant Professor — ANATOMY, resigned 9-1-74.

Cowan, Linda, Instructor — SOCIAL & PREVENTIVE MEDICINE, resigned 8-23-74.

Dunn, James Edwin, Assistant Professor — SURGERY, resigned 9-3-74.

Punchard, Joyce K., Assistant — CELL BIOLOGY & PHARMACOLOGY, resigned 7-20-74.

Smith, Earl B., Research Associate — PATHOLOGY — resigned 6-30-74.

Penttila, Antti, Research Associate — PATHOLOGY — resigned 6-19-74.

Koski, Carol Lee, Associate — NEUROLOGY — resigned 6-30-74.

Meredith, George M., Instructor — SURGERY — resigned 6-30-74.

Osterman, Joseph, Assistant Professor — MICROBIOLOGY — resigned 5-31-74.

Cucinell, Elynore, Clinical Assistant Professor — NEUROLOGY — resigned 6-21-74.

Elwood Lawrence, Assistant Professor — REHABILITATION MEDICINE — resigned 6-30-74.

Huang, Jackson C., Instructor — OBSTETRICS/GYNECOLOGY — resigned 6-30-74.

Hisley, John C., Assistant Professor — OBSTETRICS/GYNECOLOGY — resigned 6-30-74.

Dixon, Douglas, Director Child Life — PEDIATRICS — resigned 6-30-74.

Yuen, Karen K., Assistant Professor — SOCIAL & PREVENTIVE MEDICINE — resigned 6-30-74.

Harper, Robert G., Instructor — PEDIATRICS — resigned 6-30-74.

**DAVIDGE HALL  
IS A PRICELESS HERITAGE**  
**SUPPORT ITS RESTORATION!**

"Contributions" were at one time carried into Davidge Hall's back door from Cider Alley in large casks to wind up in the hidden corridor dissection rooms. Davidge Hall does not need cadavers now—but it does need funds for restoration. Send your contributions to the Davidge Hall Restoration Fund % Maryland Medical Alumni Association, 522 W. Lombard Street, Baltimore, Maryland 21201.

# ALUMNI NEWS REPORT

## TO THE BULLETIN:

I would like to report the following: \_\_\_\_\_

## **SUGGESTIONS FOR ITEMS**

## American Board Certification

### **Change of Office or Address**

## Residency Appointment

## Research Completed

## News of Another Alumnus

### Academic Appointment

## Interesting Historic Photographs and Artifacts

Scientific Articles

Name \_\_\_\_\_

### Address

George H. Yeager, M.D.

#### **Editor, Alumni Bulletin**

University of Maryland  
School of Medicine

School of Medicine  
Room 107, Gault Hall

Room 107 Gray Laboratory  
Baltimore, Maryland 21201

Baltimore, Maryland 21201











